

Applied Resolutions LLC

Notice of Independent Review Decision

Case Number

Date of Notice: 5/21/2019 3:45:02 PM CST

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: Clinical Records –XX

- Texas Workers' Compensation Work Status Reports XX
- Peer Review Reports –XX
- Utilization Review Reports – XX
- Letter of Medical Necessity –XX
- Diagnostic Data –XX

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX who sustained an injury on XX. XX XX and injured XX XX XX as well as XX XX. On XX, XX. XX was seen by XX, MD for XX. XX complained of pain was described as XX and XX, which was XX. XX experienced increased pain with XX, when reaching XX, when XX at XX, and with XX. The pain was rated at 7/10. The symptoms were better with rest. On examination of the XX, the range of motion showed XX. The strength was XX, and +XX. The examination of the XX showed range of motion of XX degrees. The strength was XX.XX, and XX. X-ray of the XX showed no XX. X-ray of XX revealed no XX or XX. The XX structures appeared well, mineralized, and well aligned. XX was noted. The treatment plan included XX for the XX disorder. X-ray of the XX dated XX revealed no fracture, or other acute abnormality. X-ray of the XX showed no fracture or other acute abnormality, mild XX (AC) joint XX changes, and postoperative XX. There was questionable subtle loosening of the XX. The treatment to date included medications (XX, XX, XX, and XX drugs (NSAIDS), rest, XX XX/XX/XX, and XX (not helpful). Per a utilization review letter dated XX and peer review dated XX, the request of XX for XX XX was denied by XX, DO. Rationale: "In this case, the claimant has had undergone prior XX sessions with no pain relief as indicated in the most recent note. Additionally, it was also noted that the claimant has started XX sessions on XX, but it was not clearly indicated as to how many visits were completed nor what the outcome of said XX. Furthermore, the requested sessions of XX for the XX exceeds the guidelines recommendations. Therefore, the request of XX two to three times per week for four to six weeks for XX XX is not medically necessary." An appeal letter was written by Dr. XX on XX. He stated that XX and XX was medically indicated, necessary, and reasonable with reference to the accepted standards of care for XX. XX' diagnosis due to extremity pain, weakness, and instability. Specifically, XX. XX had clear signs of XX on examination and had failed XX, XX, and time. Per an adverse determination letter dated XX and peer review dated XX, the prior denial was upheld by XX, XX. After reviewing the medical record, he documented that, "the claimant had an initial XX evaluation on XX. While it is unclear how many sessions XX has attended, XX did not report any benefit from it. Dr. XX appeal letter did not address this issue. Therefore, the request of XX two to three times per week for four to six weeks for XX XX is not medically necessary."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The ODG supports up to 10 sessions of XX for the medical management of XX/XX syndrome/XX. The documentation provided indicates that the injured worker has complaints of XX which is worse with XX activity as well as at night. A

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physical exam of the XX documented reduced range of motion on the XX more than XX, XX, positive XX, and positive XX test. Previous treatment has included XX, XX, XX XX XX and XX. The injured worker reported that XX was not helpful. It is unclear how many previous XX sessions were attended. The treating provider has recommended 8-18 additional XX sessions for the XX XX. Based on the documentation provided, the ODG would not support the requested additional XX visits as it is unclear how many previous therapy sessions were attended and if they were efficacious. Given the documentation available, the requested service(s) is considered not medically necessary and therefore upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG, 2019;; ODG Guidelines