



IRO#
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DATE OF REVIEW: 05.12.08 AMENDED DECISION 05.19.08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3 X wk X 6 wks for a total of 18 visits

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This case was reviewed by a Texas licensed MD, specializing in Preventive Medicine/Occupational Medicine. The physician advisor has the following additional qualifications, if applicable:

ABMS Preventive Medicine: Occupational Medicine

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Physical Therapy 3 X wk X 6 wks for a total of 18 visits		-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	URA Initial Review		10	04/08/2008	04/08/2008
2	URA Appeal Review		10	04/14/2008	04/14/2008
3	Office Visit		7	03/18/2008	03/18/2008

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records provided document that the date of injury is xx/xx/xx. The diagnoses provided are Right shoulder joint, right wrist/hand, lumbosacral Region and right-left knee joint pain. There is an extensive note from 3/18/08 that deliniates the patient's injury and the body areas that have been injured. A number of diagnoses are provided, the majority are strains/sprains. The patient was apparently walking when she sustained a fall and contused a number of body areas.

This is an extensive note from Dr., 6 pages in length, with a date of 3/18/08. It has been reviewed including the subjective complaints and clinical findings on examination of the abovementioned injured body areas. The diagnoses provided have also been reviewed. At the end of this assessment there is a request for 18 visits to supervised rehab. It is documented that the patient had not had supervised rehab previously and that this was an initial request for rehabilitation.

There was an appeal level denial on 4/14/08. The rationale for the denial was based on the fact that the requesting provider did not submit additional documentation that addresses the rationale for the initial denial. A peer-to-peer conversation did take place.

Initial level denial took place on 4/7/08. The rationale for that denial has been reviewed. A peer-to-peer conversation did not take place.

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

The patient's injury stemmed from a fall. The number of body areas allegedly injured were numerous. However, it does not appear, based on the documentation provided, that anything more significant than some contusions were sustained by the patient due to the occupational injury.

Based on the note from the treating HCP from 3/13/08, the request for 18 visits to supervised rehabilitation was an initial request for rehab services.

ODG is quite clear that patients should be evaluated after a six visit clinical trial to see if the patient is moving in a positive, negative or no direction prior to continuing with physical therapy.

Thus the initial request for 18 visits to therapy/rehabilitation was indeed grossly outside of ODG recommendations for initial rehabilitative services.

The conclusions reached by the initial and the appeal-level peer reviewers were correct in that the request for 18 visits to rehab was outside of ODG recommendations.

Thus I concur with the reviewing physicians that the initial request for 18 rehab visits was indeed outside of ODG recommendations and there was not a compelling reason provided by the treating HCP why ODG recommendations should be exceeded in this case.

It should also be pointed out that the majority of diagnoses (such as strain/sprain) that were assigned by the treating HCP were not substantiated by the documented physical exam findings and, more importantly, the diagnoses were not consistent with the mechanism of injury which was clearly a contusion of a variety of body areas that were diagnosed as strains.

Thus the assessment and the conclusion reached by the initial and appeal reviewers was correct and I uphold their adverse determination for 18 rehabilitation visits.

ODG-TWC ODG preface -

There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted; and (7) Generally there should be no more than 3 or 4 modalities/procedural units in total per visit, allowing the PT visit to focus on those treatments where there is evidence of functional improvement, and limiting the total length of each PT visit to 45-60 minutes unless

additional circumstances exist requiring extended length of treatment. If additional circumstances are present, documentation must support medical necessity.

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

ODG:

ODG-TWC ODG preface -