

True Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: September 2, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy three times a week for three weeks, visits 25-33.

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Peer reviews, 07/0/08, 07/28/08

Pre-operative history and physical, 04/23/08

Office note, Dr. 04/14/08

Office note, Dr. 04/18/08, 07/28/08

Operative report, 04/25/08

Functional Capacity Evaluation, 08/12/08

PT progress notes, 04/28/08 to 07/09/08, 05/23/08, 06/09/08 06/30/08

Authorization request, 05/05/08, 05/23/08, 06/11/08, 07/032/08, 08/13/08

MD referral form, 05/19/08, 07/28/08

MRI right arm, 04/10/08

Chest x-ray, 04/23/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This male claimant was diagnosed with a distal biceps tendon tear after a reported injury on xx/xx/xx. The claimant was initially treated conservatively with continued pain and weakness of the right arm. A repair and reattachment of the biceps tendon at the right elbow was performed on 04/15/08.

The records indicated that the claimant attended approximately thirty sessions of physical therapy post-operatively. A therapy progress record dated 06/30/08 noted the claimant with no pain at rest and some limitations with biceps strength still present.

A physician examination dated 07/28/08 revealed the claimant three months post-operative and progressing well and making good progress with strength, range of motion and function. Pain levels were minimal except with exercise. On examination, there was tenderness over the well healed incisional site. According to the treating physician, the claimant had a distal bicipital avulsion which included the entire muscle and therefore the need for continued physical therapy, a functional capacity evaluation and a work conditioning program. A functional capacity evaluation followed on 08/12/08 which placed the claimant in a medium to heavy work category. The records indicated that the claimant had approximately thirty sessions of post-operative physical therapy.

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

The request for an additional nine sessions of physical therapy cannot be justified based on a careful review of all the medical records.

The patient is now over four months postoperative and has already received 24 sessions of physical therapy. The patient reportedly has a good range of motion of the elbow with some mild deficits in strength. Strength would be expected to improve with, and ODG recommends, a transition to a home exercise program. Formal physical therapy would not be expected to allow functional gains at this interval given the normal motion that is reported.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Elbow: Physical therapy

Rupture of biceps tendon - Post-surgical treatment: 24 visits over 16 weeks

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**