

Notice of Independent Review Decision

DATE OF REVIEW:

10/22/2009

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Twelve sessions of physical therapy (three times per week for four weeks).

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

Board Certified Physical medicine and Rehabilitation Physician

REVIEW OUTCOMEUpon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.**Twelve sessions of physical therapy (three times per week for four weeks) is not medically necessary.****INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 10/14/09 MCMC Referral
- 10/14/09 Notice to Utilization Review Agent of Assignment, DWC
- 10/14/09 Notice to MCMC, LLC of Case Assignment, DWC
- 10/13/09 Confirmation of Receipt of a Request For a Review, DWC
- 10/12/09 Request For a Review By An Independent Review Organization
- 10/08/09 letter from M.D.,
- 09/30/09 Request for Reconsideration, M.D., Clinic
- 09/25/09 Notification of Determination letter, D.O.,
- 09/22/09, 10/01/09 Fax Cover Sheets with notes from Clinic
- 09/22/09, 10/01/09 Request For Preauthorization and Concurrent Review, Clinic
- 09/22/09 Consultation and Letter of Medical Necessity for Bilateral Transforaminal ESI, M.D., Back Pain Center
- 09/21/09 Physical Therapy Progress Note, M.D., Clinic
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male with multiple diagnostic presentations. This includes fracture of the distal radius, left knee and lumbar area. There is no specific detailed examination of the wrist area except on 09/21/2009 and on the lower back except on 09/22/2009. Serial measurements of clinical improvements are not given for the wrist or lumbar area. The injured individual has received sixteen physical therapy sessions which based on documentation is to the wrist area. Standard treatment guidelines for post fracture wrists are up to sixteen visits over eight weeks. The injured individual is six months post fracture (date of injury xx/xx/xx). There is no data to indicate non union of fracture which should be healed by this time. The attending provider (AP) requests another twelve treatments of Physical Therapy.

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

There is lack of documentation to support that the prior physical therapy has helped the injured individual in regards to the wrist or the lower back. There are no serial objective measurements from the physical therapist or AP showing that therapy was of benefit for this injured individual. The Official Disability Guidelines indicate up to sixteen visits over eight weeks and the injured individual has already had sixteen weeks of therapy for the wrist, nine visits over eight weeks for lumbago and as time goes by. One should see an increase in active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency. Home exercise program should be stated in the beginning and must include ongoing assessments of compliance as well as upgrades to the program. There is no documentation of this occurring. Other guidelines such as American College of Occupational and Environmental Medicine (ACOEM) 2nd ed. Chapter 3 page 48 indicate a need for objective short and long term goals follow up by the physician and therapist. There is no serial objective data base showing improvement.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES