

SENT VIA EMAIL OR FAX ON
Jul/14/2011

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/14/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 2 x wk x 4 wks Left Femur Back

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

M.D., Board Certified Orthopedic Surgery

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

1. Utilization review notice of determination 05/06/11 regarding non-certification EMG/NCV bilateral lower extremities
2. Utilization review determination 06/02/11 regarding non-certification appeal EMG/NCV bilateral lower extremities
3. Precertification request and appeal request 8 occupational / physical therapy (2 times a week x 4 weeks)
4. Letter of medical necessity M.D.
5. Physical therapy notes 02/23/11-05/26/11
6. Operative report 11/15/10 valgus producing osteotomy taking malunion site from 120 degrees to 140 degrees and removal of trochanteric nail from syntheses
7. Utilization review notice of adverse determination 05/26/11 regarding non-certification occupational / physical therapy (2 times a week x 4 weeks left femur, back)
8. Utilization review notification of reconsideration determination 06/16/11 regarding non-certification appeal occupational / physical therapy (2 times a week x 4 weeks left femur, back)

9. New patient evaluation and office notes, M.D. 04/19/11-06/03/11

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a female whose date of injury is xx/xx/xx. She is noted to have sustained multiple injuries secondary to fall including left wrist fracture and left hip fracture. She underwent ORIF of left hip and ORIF of left wrist. Records indicate she had failure of hardware. The injured employee underwent a valgus producing osteotomy taking the malunion side from 120 degrees to 140 degrees, and removal of trochanteric nail. The patient participated in physical therapy from 02/23/11-05/26/11 based on records provided.

A request for additional therapy x 8 sessions (2 times a week for 4 weeks) was reviewed on 05/26/11 and the request was non-certified as medically necessary. The reviewer noted the injured employee had attended 28 physical therapy sessions as of 05/13/11, and the number of physical therapy sessions requested on top of previously rendered sessions exceeds guideline recommendations. It was noted that the latest medicals did not include exceptional factors that would substantiate the additional physical therapy sessions. There was no evidence that the remaining deficits could not be addressed by home exercise program, and medical necessity of the request was not established.

A reconsideration / appeal request for physical therapy 2 times a week x 4 weeks left femur, back was reviewed on 06/16/11 and non-certified as medically necessary. Records indicate there was prior non-certification given that physical therapy sessions requested on top of previously rendered therapy exceeds guideline recommendations, and latest medicals did not include exceptional factors that would substantiate the additional physical therapy sessions. There is no evidence the remaining deficits could not be addressed by home exercise program. There was documentation that the injured employee had attended 28 physical therapy sessions. The requesting physician states the injured employee needs physical therapy for function, strength, safety and flexibility; however, there is no documentation from the treating physician of exceptional factors that would substantiate the need for additional physical therapy sessions. Additionally, there was no documentation from the treating physician of objective improvement with previous therapy, functional deficits, functional goals, and statement identifying why home exercise program would be insufficient to address any remaining functional deficits. Furthermore, the number of sessions requested exceeds current evidence based guideline recommendation. Therefore, medical necessity of the request is not substantiated.

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

Based on the clinical information provided, medical necessity is not established for additional physical therapy 2 times a week x 4 weeks. The injured employee sustained multiple injuries secondary to a fall resulting in ORIF of the left hip in xx/xx. There was subsequent failure of hardware. The injured employee underwent a valgus producing osteotomy taking the malunion side from 120 degrees to 140 degrees and removal of trochanteric nail performed xx/xx/xx. The injured employee is noted to have completed 28 visits of therapy as of 05/13/11; however, the total number of therapy sessions including post-op therapy following initial ORIF was not documented. Official Disability Guidelines would support up to 24 visits of therapy in this instance. The injured employee has already completed 28 sessions of therapy, and the request for additional therapy would clearly exceed guidelines. There is no documentation of exceptional factors to substantiate the need for additional formal therapy. There also is no explanation as to why remaining deficits could not be addressed by an independent home exercise program. As such the request for additional physical therapy two times a week times four weeks left femur back is not indicated as medically necessary.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES