

IRO Express Inc.

An Independent Review Organization

2131 N. Collins, #433409

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy 3 X wk X 2 wks right shoulder and wrist

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

Board Certified PM&R

Board Certified Pain Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

Utilization review determination dated 08/24/12, 09/12/12

Initial evaluation dated 02/21/12

Follow up evaluation dated 02/24/12, 02/29/12, 03/06/12, 03/12/12, 03/26/12, 03/30/12, 04/09/12, 04/16/12, 04/30/12, 05/07/12, 05/24/12, 06/04/12, 06/11/12, 06/19/12, 06/26/12, 07/12/12, 07/25/12, 08/03/12, 08/14/12, 08/28/12, 09/03/12, 09/13/12, 09/24/12, 09/26/12

Request for authorization of physical therapy dated 09/19/12

Operative report dated 03/23/12

MRI right hand dated 03/07/12

MRI right wrist dated 03/07/12

Office visit note dated 03/02/12, 03/08/12, 04/12/12, 04/26/12, 05/10/12, 05/11/12, 06/07/12, 07/03/12, 07/24/12, 08/06/12, 08/21/12

MMI/IR rating dated 07/09/12

Physical therapy evaluation dated 05/16/12

Physical therapy daily note dated 05/22/12, 05/23/12, 05/30/12, 05/31/12, 06/01/12, 06/05/12, 06/06/12, 06/08/12, 06/12/12, 06/14/12, 06/18/12, 06/27/12, 06/29/12, 07/02/12, 07/16/12, 07/18/12, 07/20/12, 07/27/12, 07/30/12, 08/01/12, 08/08/12, 08/09/12, 08/10/12, 08/15/12, 08/16/12, 08/17/12, 08/22/12, 08/23/12, 08/24/12

MRI right shoulder dated 06/13/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient fell forward injuring his right wrist. X-rays were positive for avulsion fracture of the right wrist. MRI of the right wrist dated 03/07/12 revealed nondisplaced intraarticular fracture of the distal radius with associated marrow edema. The patient underwent ORIF of right wrist fracture arthroscopy, arthrotomy and open repair of triangular fibrocartilage complex on 03/23/12. The patient subsequently completed approximately 34 physical therapy visits. MRI of the right shoulder dated 06/13/12 revealed small right glenohumeral joint effusion; mild tendinosis involving the supraspinatus tendon without evidence of a rotator cuff tear; mild degenerative joint disease involving the right AC joint; and mild subacromial/subdeltoid bursitis. MMI/IR evaluation dated 07/09/12 indicates that the patient has reached maximum medical improvement with 4% whole person impairment. Follow up note dated 08/21/12 indicates that the patient was recently laid off. His symptoms are okay at the present time. On physical examination no motor or sensory deficits are noted. There is mild weakness of abduction. Active forward elevation is 140 degrees. At this point his symptoms are stable. The patient as recommended to simply continue his home exercise program and stretching.

Initial request for physical therapy 3 x wk x 2 wks right shoulder and wrist was non-certified on 08/24/12 noting that the patient has already received 34 visits of physical therapy treatment for the right shoulder and wrist that well exceeds the guideline criteria and the additional therapy would be further in excess of the guidelines. It also appears that reasonably good overall functional improvement has been achieved and no indication of any significant objective functional limitations occurring in the affected segments. For any residual functional deficits the patient should be able to transition into a daily home exercise program for the long term. The denial was upheld on appeal dated 09/12/12 noting that the ODG recommendations have been far exceeded. Additionally, in speaking with Dr., she stated that further therapy was not going to give him much better and that they, in the clinic, were ready to do an impairment rating.

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

Based on the clinical information provided, the request for physical therapy 3 x wk x 2 wks right shoulder and wrist is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent ORIF of right wrist fracture arthroscopy, arthrotomy and open repair of triangular fibrocartilage complex on 03/23/12 and subsequently completed 34 physical therapy visits. The Official Disability Guidelines support up to 16 visits for the patient's diagnoses, and there is no clear rationale provided to support continuing to exceed these recommendations. There are no exceptional factors of delayed recovery documented. The patient was determined to have reached maximum medical improvement with 4% whole person impairment. Follow up note dated 08/21/12 indicates that the patient's symptoms are stable and the patient was recommended to continue his home exercise program and stretching. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

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

ACOEM-AMERICA 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)