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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jan/25/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions (3 X 4) of Additional Physical Therapy for the Cervical Spine

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

Board Certified Orthopedic Surgeon (Joint)

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
Incident report dated 01/25/12
CT scan of the cervical spine dated 01/25/12
CT scan of the head dated 01/25/12
X-ray of the right humerus dated 01/25/12
Procedure note dated 01/25/12
Employer's 1st report of injury or illness dated 01/26/12
Pre-authorization determination letter dated 03/14/12
Adverse determination letter dated 04/04/12
Pre-authorization determination letter dated 04/18/12
Adverse determination letter dated 05/01/12
Adverse determination letter dated 05/14/12
Pre-authorization determination letter dated 05/17/12
Adverse determination letter dated 06/04/12
Pre-authorization determination letter dated 06/08/12
Adverse determination letter dated 06/25/12
Pre-authorization determination letter dated 07/10/12
Pre-authorization determination letter dated 07/13/12
Procedure note dated 07/18/12
Pre-authorization determination letter dated 08/21/12
Pre-authorization determination letter dated 08/22/12

Pre-authorization determination letter dated 09/20/12
Pre-authorization request dated 10/15/12
Adverse determination letter dated 10/19/12
Amended adverse determination letter dated 10/26/12
Amended pre-authorization determination letter dated 10/30/12
Spine evaluation dated 12/04/12
Physical therapy summary and re-evaluation dated 12/04/12
Physical therapy note dated 12/04/12
Physical therapy prescription dated 12/07/12
Adverse determination letter dated 12/13/12
Letter dated 12/17/12
Adverse determination letter dated 01/02/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped in a hallway and struck her head and arm on the wall. CT scan of the cervical spine dated 01/25/12 revealed changes of degenerative spondylosis are seen at C5-6 and C6-7 in the form of small marginal osteophytes and disc space narrowing. The prevertebral soft tissues are unremarkable. CT of the head dated 01/25/12 revealed no acute intracranial abnormality. The patient sustained a fracture of the proximal humerus diaphysis and underwent intramedullary rodding of right proximal humerus fracture with diaphyseal extension on 01/25/12 followed by a course of physical therapy. The patient subsequently underwent right shoulder manipulation and right olecranon bursal resection on 07/18/12. The patient completed 30+ postoperative physical therapy visits. Spine evaluation dated 12/04/12 indicates that diagnosis is cervical strain/sprain. The patient has completed 12 physical therapy visits for the neck and has progressed slowly due to continued pain. On physical examination cervical range of motion is limited 50% flexion, 45% extension, 70% right rotation, 75% left rotation, 75% right lateral flexion and 85% left lateral flexion. MMT is rated as 3+/5.

Initial request for 12 sessions of additional physical therapy for the cervical spine was non-certified on 12/13/12 noting that ODG would support an expectation for and ability to perform a proper non-supervised rehabilitation regimen for the described medical situation when an individual has received the amount of supervised rehabilitation services previously provided. Appeal letter dated 12/17/12 indicates that the patient has decreased strength. Her cervical posture has improved, but she still has a postural breakdown and deviations. She has continued muscle tightness and spasms and her overall activity tolerance remains impaired by persistent pain. The denial was upheld on appeal dated 01/02/13 noting that there were already 12 sessions of formal therapy authorized on 10/26/12. The therapy note of 12/04/12 reported slow progress.

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 12 sessions (3 x 4) of additional physical therapy for the cervical spine is not recommended as medically necessary, and the two previous denials are upheld. The patient has previously completed 12 sessions of physical therapy for the cervical spine. The Official Disability Guidelines support up to 10 visits for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. There is no clear rationale provided as to why any remaining deficits cannot be addressed with an active home exercise program. 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 as recommended by the guidelines.

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)