

# P-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

May/30/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

12 Physical Therapy Visits for the Right Distal Radius

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

Board Certified Family Practice

**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:**

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 04/10/13, 04/25/13, 03/07/13, 02/07/13

Exercise chart dated 02/14/13-04/08/13

Therapy prescription dated 04/05/13, 05/03/13, 03/01/13, 01/29/13

Office note dated 05/03/13, 03/01/13, 04/05/13

Procedure note dated 01/21/13

Daily therapy treatment note dated 04/08/13, 03/05/13, 04/03/13, 04/01/13, 03/28/13, 03/27/13, 03/25/13, 03/21/13, 03/20/13, 03/18/13, 03/14/13, 03/13/13, 03/11/13, 03/08/13, 03/05/13, 02/28/13, 02/27/13, 02/25/13, 02/21/13, 02/20/13, 02/18/13, 02/15/13, 02/14/13

Handwritten re-evaluation dated 04/04/13, 02/28/13, 02/06/13

Visit summary dated 01/09/13, 01/16/13, 01/23/13, 02/15/13, 03/06/13, 04/09/13, 05/10/13

MA/Nurse notes dated 05/10/13, 04/09/13, 03/06/13, 02/15/13, 01/23/13, 01/16/13, 01/09/13

Letter dated 05/10/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped and fell at work and sustained a comminuted displaced distal radius and ulnar styloid fracture. The patient underwent ORIF distal radius fracture on 01/21/13 and subsequently completed 24 postoperative physical therapy visits to date. Visit note dated 04/05/13 indicates that wrist range of motion is supination 40, pronation 70, extension 25 and flexion 40 degrees. Provocative tests are negative. Neurological exam shows normal findings.

Initial request for 12 physical therapy visits for the right distal radius between 04/22/2013 and 06/21/2013 was non-certified on 04/10/13 noting that the referenced treatment guidelines recommend up to 16 postoperative PT visits for the patient's condition. Should treatment exceed this recommendation, exceptional factors must be noted. This patient has had an

extensive course of therapy but remains with impaired range of motion and strength. Although continuing with treatment may be beneficial, extenuating factors to support 12 additional visits of therapy were not discussed. The denial was upheld on appeal dated 04/25/13 noting that the clinical notes lacked evidence of exceptional factors to support continued supervised therapeutic interventions at this point in the patient's treatment. Continued use of an independent home exercise program for increased strengthening and range of motion to the right wrist would be indicated.

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

The patient sustained a comminuted displaced distal radius and ulnar styloid fracture and underwent ORIF distal radius fracture on 01/21/13. The patient has subsequently completed 24 postoperative physical therapy visits to date. The Official Disability Guidelines Forearm, Wrist and Hand Chapter supports up to 16 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. 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 such, it is the opinion of the reviewer that the request for 12 physical therapy visits for the right distal radius is not recommended as medically necessary.

**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)