

# US Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** May/29/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** additional physical therapy 3x3

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D. Board Certified Orthopedic Surgeon

**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.** It is the opinion of this reviewer that medical necessity is not established for additional physical therapy 3x3

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
IRO request/referral documents  
Utilization review determination/denial 04/22/13  
Utilization review reconsideration/upheld 05/02/13  
Pre-authorization request 04/17/13  
Pre-authorization appeal 04/25/13  
Physical therapy initial evaluation and daily progress notes 03/14/13-04/22/13  
Physical therapy appeal letter 04/24/13  
Office note MD 02/28/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The claimant is a female whose date of injury was xx/xx/xx. Records indicated that the claimant was injured when she fell off of a truck at work. She sustained a lateral malleolus fracture and per office note dated 02/28/13 the claimant returned to work but noted that he still had some achy discomfort particularly towards the end of the day. It appeared that the claimant participated in physical therapy 03/14/13 through 04/22/13. Per progress note dated 04/15/13 the claimant reported improvement with increased range of motion, decreased pain, and increased strength. As of this date the claimant had been seen for 10 visits and missed no visits. It was noted that although the claimant had progress she still had deficits and weakness. Continued physical therapy was recommended.

A request for physical therapy three times three was non-certified on 04/22/13 noting that the claimant had at least 10 prior approved physical therapy sessions with apparent improving function and mobility, and it appeared reasonable to transition to home exercise program.

A reconsideration request for additional physical therapy three times three was non-certified on 05/02/13, referencing initial non-certification noting it was reasonable to expect a full

transition to home exercise program after initial program of directed therapy sessions if post injury course remained without undue complications with this diagnosis. It was again noted that the claimant had prior physical therapy with at least 10 approved visits with apparent improving function and mobility, and it appeared reasonable to transition to home exercise program at this time.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The records submitted for review reflect that the claimant sustained an injury when she fell off a truck at work and sustained a lateral malleolus fracture. The claimant was placed in a boot and prescribed formal physical therapy. The claimant returned to work. The claimant had completed 10 physical therapy sessions as of 04/15/13, with documented improvement with increased range of motion, decreased pain, and increased strength. As noted by the previous reviewers, it appears that the claimant should have been transitioned to an independent self-directed home exercise program following a course of formal supervised therapy. Based on the clinical data provided, it is the opinion of this reviewer that medical necessity is not established for additional physical therapy 3x3 as there is no evidence of exceptional factors that would warrant therapy in excess of guideline recommendations. Accordingly the previous denial should be upheld on IRO.

**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)