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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/27/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: physical therapy 3xWk x 4Wks right hand

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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)

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 the reviewer that the request for physical therapy 3 x wk x 4 wks right hand is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient underwent repair of right median nerve, ulnar nerve and ulnar artery in distal forearm on the date of injury. Initial evaluation dated 04/11/14 indicates that the patient reports completing approximately 27 sessions of therapy. The patient subsequently underwent flexotenolysis of right small finger, middle finger and index finger, MCP joint capsulotomy at right small finger, ring finger, middle finger and index finger, PIP joint capsulotomy at right small finger, ring finger, middle finger and index finger on 06/12/14. Note dated 07/15/14 indicates that the patient is doing physical therapy 3 times a week. PPE dated 08/19/14 indicates the patient has completed 12 postoperative physical therapy visits to date. Progress note dated 08/26/14 indicates that the patient complains of right hand swelling and pain after therapy. Medications are Tylenol and Gabapentin. On physical examination there is weak contraction of finger flexors in forearm, diminished intrinsics and no opposition present.

The initial request for physical therapy 3 x wk x 4 wks was non-certified on 09/02/14 noting that the patient has completed 18 postoperative physical therapy visits since revision surgery. The evidence based guidelines suggest a maximum of 14 sessions for this type of tendon capsule revision surgery. Now that the patient has reached the maximum allowable treatment point according to the guidelines, ongoing care should be limited to 6 visits to prove ongoing efficacy with exceptional factors. There are no significant exceptional factors documented. The denial was upheld on appeal dated 09/24/14 noting that 6 visits would be appropriate in accordance with the Official Disability Guidelines; however, 12 visits exceeds recommendations.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent flexotenolysis of right small finger, middle finger and index finger, MCP joint capsulotomy at right small finger, ring finger, middle finger and index finger, PIP joint capsulotomy at right small finger, ring finger, middle finger and index finger on 06/12/14 and has completed 18 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 24 sessions of physical therapy 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. As such, it is the opinion of the reviewer that the request for physical therapy 3 x wk x 4 wks right hand 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 KNOWLEDGBASE

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)