

# US Decisions Inc.

An Independent Review Organization  
8760 A Research Blvd #512  
Austin, TX 78758  
Phone: (512) 782-4560  
Fax: (207) 470-1085  
Email: [manager@us-decisions.com](mailto:manager@us-decisions.com)

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jul/10/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 16 sessions of physical therapy to the left leg

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., Board Certified Physical Medicine and 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.** It is the opinion of the reviewer that the request for 16 sessions of physical therapy to the left leg is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. On this date she fell at work. The patient sustained a left intertrochanteric femur fracture. She underwent subsequent ORIF on 10/23/13. Note dated 02/14/14 indicates that strength of the left lower extremity is -3/5 hip abduction and extension, +3/5 hip flexion and knee extension and -4/5 knee flexion. Left hip range of motion is flexion 100. Re-evaluation dated 05/15/14 indicates that the patient has completed 33 physical therapy visits to date. On physical examination strength is unchanged with the exception of 4/5 hip flexion and knee flexion and +4/5 knee extension.

Initial request for 16 sessions of physical therapy was non-certified noting that no recent notes from the surgeon are submitted for review. It is questionable that further therapy beyond a home program would be of benefit for rehabilitation that typically involves up to 24 visits. The denial was upheld on appeal dated 06/17/14 noting that ODG would support up to 24 postoperative physical therapy sessions. The records reflect that the claimant has completed 33 sessions of outpatient physical therapy and has undergone significant inpatient rehabilitation. No significant improvement was noted in the physical therapy notes provided.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained a left intertrochanteric femur fracture. She underwent subsequent ORIF on 10/23/13. She has

subsequently completed 33 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. 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 16 sessions of physical therapy to the left leg 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)