

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jan/29/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 8 physical therapy visits for the right leg

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., 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 8 physical therapy visits for the right leg is not recommended as medically necessary.

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

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 10/23/13, 11/26/13  
Letter dated 10/31/13  
Progress note dated 10/03/13, 09/19/13, 07/16/13, 08/06/13, 08/27/13  
Operative report dated 06/17/13  
Daily note dated 10/01/13, 09/26/13, 09/24/13, 08/08/13, 08/13/13, 08/15/13, 08/20/13, 08/22/13, 08/27/13, 09/03/13, 09/05/13, 09/10/13, 09/12/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The patient sustained a femoral shaft fracture after he slipped and fell. The earliest record submitted for review is an operative report dated 06/17/13. The patient had a nonunion of his right distal femur and underwent ORIF of nonunion with bone grafting and removal of hardware on 06/17/13. Daily note dated 08/08/13 indicates that the patient was released to light duty at work. He reports having stiffness. The patient completed 23 physical therapy visits. Progress note dated 10/03/13 indicates that the patient feels like he is continuing to progress with better strength and mobility. He still has some right knee pain rated as 4/10. Active range of motion of the knee is flexion 97, extension -10 degrees.

Initial request for 8 physical therapy visits was non-certified on 10/23/13 noting that the guidelines recommend a total of 30 postoperative visits for the patient. The current request on top of the completed sessions is in excess of guideline recommendations. Compelling factors to substantiate the request were not mentioned. There was noted improvement from the initial of therapy, but the most recent physical therapy notes did not demonstrate that there was significant functional improvement (especially from 08/27/13 to 10/03/13). The reason for the patient's plateauing response was not mentioned and addressed. Letter dated

10/31/13 indicates that the patient has a persistent limp and pain when he attempts to bear full weight on his right leg. His progress recently plateaued due to increasing knee/bone pain. Functionally he continues to have a 74% deficit, which is unacceptable at this stage of his rehab. The denial was upheld on appeal dated 11/26/13 noting that the patient has completed 58 physical therapy visits. It was noted that the patient was unable to walk independently without using a rolling walker or a cane and to have plateaued. Clinical documentation submitted for review fails to provide documentation of exceptional factors to warrant non adherence to guideline recommendations.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient underwent ORIF of nonunion with bone grafting and removal of hardware on 06/17/13 and has completed 58 physical therapy visits to date. The Official Disability Guidelines support up to 30 visits for fracture of femur and up to 52 visits for abnormality of gait, 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 8 physical therapy visits for the right 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)