

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Feb/24/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Post-Op PT 2 x a week x 4 weeks (8 total)

**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 Post-Op PT 2 x a week x 4 weeks (8 total) is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The patient fell landing on his right arm. Peer review dated 06/17/13 indicates that the patient sustained a right wrist fracture. The patient underwent ORIF comminuted intraarticular distal radius fracture on 11/10/12. The patient subsequently underwent right shoulder manipulation under anesthesia on 10/02/13. The patient completed 12 postoperative physical therapy visits. Follow up note dated 12/13/13 indicates that impingement signs of the right shoulder are negative. Range of motion is well-preserved. He still has fairly significant weakness of abduction and external rotation. Note dated 01/24/14 indicates that he has approximately 70% of normal shoulder range of motion. Internal rotation is noted to be particularly bad. He was placed at maximum medical improvement with 14% whole person impairment.

Initial request for postoperative physical therapy 2 x a week x 4 weeks was non-certified on 12/05/13 noting that the patient has had extensive postoperative rehab after the wrist surgical procedure. The patient also has completed at least 12 supervised rehab sessions postoperative after the 10/02/13 shoulder manipulation under anesthesia. There is no documentation of the progress made in post-op PT after shoulder manipulation under anesthesia. There are no post-op notes from the treating surgeon. There are no office notes from the office the requesting provider. There is no documentation why there are so many different providers requesting supervised rehab at different facilities. The denial was upheld on appeal dated 12/20/13 noting that the information provided is conflicting and does not indicate the specific amount of physical therapy the claimant has received to date. Also the prescription for therapy dated 12/13/13 requests 8 visits, but the original denial was for 8 physical therapy visits. The most recent physical examination on 11/23/13 did not include

passive versus active range of motion measurements for the right shoulder.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient underwent right shoulder manipulation under anesthesia on 10/02/13 and has completed at least 12 postoperative physical therapy visits to date. The patient's objective functional response to postoperative physical therapy completed to date is not submitted for review to establish efficacy of treatment and support ongoing supervised therapy. There are no specific, time-limited treatment goals provided. The patient's compliance with an active home exercise program is not documented. As such, it is the opinion of the reviewer that the request for Post-Op PT 2 x a week x 4 weeks (8 total) 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)