

Notice of Independent Review Decision

DATE OF REVIEW: 4/7/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 sessions of physical therapy for the left proximal humerus as requested.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The TMF physician reviewer is a licensed Orthopedic Surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the 12 sessions of physical therapy for the left proximal humerus as requested is not medically indicated to treat this patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker is a xx who fell from a ladder on xx/xx/xx, suffering fractures of the ribs, left hemipelvis and proximal left humerus. An open reduction internal fixation of the proximal humerus fracture was performed on 12/12/14, with repair of the pectoralis major tendon. Post operatively, the worker received physical therapy treatment with significant restoration of function; reporting 80 percent improvement. He was authorized to return to restricted work and continues to work light duty. The current request for an additional 12 sessions of physical therapy for the left proximal humerus as requested has been considered and denied.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This patient has received the ODG recommended course of physical therapy. There is no documentation of circumstances that would justify additional physical therapy at this time. The patient is capable of performing a home exercise program, the fracture is healed, and the patient has returned to modified work. The prior denials of this request to preauthorize an additional 12 sessions of physical therapy were appropriate and should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)