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## Notice of Independent Review Decision

**DATE OF REVIEW:** 6/5/2014

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of outpatient physical therapy to the left ankle, 1 time a week for 6 weeks.

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

The reviewer is a Medical Doctor who is board certified in 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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of outpatient physical therapy to the left ankle, 1 time a week for 6 weeks.

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

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

was injured on xx/xx/xx. She reportedly twisted her left foot and fell. There were complaints of pain in the left ankle, right elbow, right knee and back. On 4-9-14, there were complaints of

left ankle and back pain along with neuropathy into the feet. Objective findings were not evident. Diagnoses included that of joint pain and peroneal tendinitis, ankle ligament and plantar fascia tears with talar OCD. Treatment has included Apr. 18 sessions of (authorized) formal therapy and medications. Denial letters noted a lack of findings to support an indication for other than a prescribed and self-directed protocol of therapy. The letter of appeal with regards to ongoing therapy was noted from 4-24-14.

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

The most recent records do not evidence a combination of subjective and objective findings that would support other than a prescribed self-directed protocol of therapy-exercises. The provider's patient has already exceeded the guidelines associated quantity of therapy visits. Extenuating circumstances do not appear to have at all been provided to support additional formal supervised therapy, as per the applicable referenced clinical guidelines.

**Reference: ODG Physical Therapy Guidelines –**

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Ankle/foot Sprain (ICD9 845):

Medical treatment: 9 visits over 8 weeks

**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)**