

True Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW: 12/04/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3 x 4 weeks additional to original 12 visits

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

Master of Physical Therapy Degree

Texas State Board Physical Therapy License

Board Certified Orthopaedic Clinical Specialist Degree (OCS)

Certified Manual Physical Therapist (CMPT)

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

No ODG Guidelines

Physical Therapy Re-evaluation 10/22/07

Signed Medical Plan of Care 10/23/07

Letter of Medical Necessity 11/06/07

SRS Physician Advisor Review 10/31/07

SRS Reconsideration Review 11/13/07

PATIENT CLINICAL HISTORY [SUMMARY]:

Employee is a male with an injured ankle xx/xx/xx. Patient has had 12 physical therapy sessions. X-rays performed with no results provided. Physical re-evaluation reports full ROM but decreased strength and continued symptoms. No other history provided.

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

ODG guidelines only allow for 9 PT sessions status-post ankle sprain with a return to work time frame of 1-21 days. Physical therapy re-evaluation documents 2-3/10 pain, full ROM, 20-30 second balance, and 4-5/5 muscle strength. The evaluating therapist states continued ankle instability however the physician reports the ankle is 'stable to exam'. The physical therapy letter of medical necessity states 'limited motion' but the re-evaluation states 'ROM is WFL'. No objective measurable functional limitations are stated in the PT evaluation warranting continued physical therapy. If other diagnostics showed other pathology suggesting instability, additional PT may be warranted. Contradicting information and lack of objective data eliminates the need for additional therapy. Employee should be able to address strength gain in an appropriate home exercise program.

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
 - APTA GUIDE TO PHYSICAL THERAPY PRACTICE