

Applied Resolutions LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 07/13/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy, left ankle, three times a week for four weeks.

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

M.D., Board Certified Orthopedic Surgeon

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)

Upon independent review the reviewer finds that the requested Physical Therapy for left ankle, three times a week for four weeks is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

This worker was initially injured while working as a xxxx and her ankle “rolled out from under her.” She has had a diagnosis of ankle sprain. There has been mention made of her undergoing twelve physical therapy sessions. Apparently while she initially twisted her ankle, she has had recurrent injuries at work. Her date of injury was xx/xx/xx. The current request is for Physical Therapy for the left ankle, 3 times a week for 4 weeks.

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

Upon independent review of the provided medical records and ODG Guidelines, this reviewer finds that the requested Physical Therapy for left ankle, three times a week for four weeks is not medically necessary. This is a patient who had an ankle sprain. She

has had formalized physical therapy of one form or another for twelve visits. OGD Guidelines recommend nine visits over eight weeks for an ankle sprain. She has exceeded this significantly already. There is no evidence in the medical records to suggest that formalized physical therapy at this juncture would be any more beneficial than a home program. For this reason, the previous adverse determination has been 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
- OGD- 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)