

Applied Assessments LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 07/23/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Retrospective, medical services between 4/25/2007 and 8/06/07 as outlined on the Table below:

Begin Date	End Date	ICD-9/DSMV	HCPCS/NDC	Billing Modifiers	Service Units
4/25/07	8/6/07	824.0	G0283	00	16
4/25/07	8/6/07	824/0	97140	00	21
4/25/07	8/6/07	824/0	97110	00	51
4/25/07	8/6/07	824/0	97112	00	29
5/2/07	5/2/07	824/0	99082	TP	1
5/14/07	5/16/07	824/0	97010	00	2
5/14/07	5/14/07	824/0	97014	00	1
5/16/07	5/16/07	824/0	97035	00	1
5/24/07	6/29/07	824/0	99214	00	2
5/24/07	6/29/07	824/0	99080	73	2
6/27/07	6/27/07	824/0	97530	00	2
7/25/07	7/25/07	824/0	97116	00	1

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

M.D., 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)

Upon independent review the reviewer finds the following:

Injury Date	Review Type	Begin Date	End Date	ICD-9/DSMV	HCPCS/NDC	Billing Modifiers	Service Units	Upheld/Overturned
	Retro	4/25/07	8/6/07	824.0	G0283	00	8	Upheld
	Retro	4/25/07	8/6/07	824.0	G0283	00	8	Overturned
	Retro	4/25/07	8/6/07	824.0	97140	00	10	Overturned
	Retro	4/25/07	8/6/07	824.0	97140	00	11	Upheld
	Retro	4/25/07	8/6/07	824.0	97110	00	25	Overturned
	Retro	4/25/07	8/6/07	824.0	97110	00	26	Upheld
	Retro	4/25/07	8/6/07	824.0	97112	00	13	Overturned
	Retro	4/25/07	8/6/07	824.0	97112	00	16	Upheld
	Retro	5/2/07	5/2/07	824.0	99082	TP	1	Overturned
	Retro	5/14/07	5/16/07	824.0	97010	00	2	Overturned
	Retro	5/14/07	5/14/07	824.0	97014	00	1	Overturned
	Retro	5/16/07	5/16/07	824.0	97035	00	1	Overturned
	Retro	5/24/07	6/29/07	824.0	99214	00	2	Overturned
	Retro	5/24/07	6/29/07	824.0	99080	73	2	Overturned
	Retro	6/27/07	6/27/07	824.0	97530	00	2	Upheld
	Retro	7/25/07	7/25/07	824.0	97116	00	1	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determinations, Bills, EOBs, Denial Statements, Health Insurance Claim Forms, 4/25/07-8/6/07
 ODG Guidelines and Treatment Guidelines
 RME, 8/9/06
 Clinic, 7/3/08, 2/26/07, 3/26/07, 4/16/07, 4/25/07, 4/27/07, 5/2/07, 5/14/07, 5/16/07, 5/18/07, 5/21/07, 5/23/07, 5/24/07, 6/15/07, 6/18/07, 6/25/07, 6/27/07, 6/29/07, 7/23/07, 7/25/07, 7/30/7, 8/1/07, 8/6/07
 MD, 3/27/07, 7/4/05, 4/12/07
 3/5/08
 Email Correspondence with Carrier, 2008

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a patient who sustained a severe trimalleolar fracture of his ankle. He underwent open reduction internal fixation. He was found to be at MMI by a reviewer, but subsequent to this MMI date, the patient sustained a fracture of one of the syndesmosis screws. This was discovered in March 2007, and it resulted in him undergoing surgery on 03/27/07 after the IME physician found him to be at maximum medical improvement.

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

Removal of hardware, particularly syndesmosis screws, is known to be a requirement post instrumentation of a fracture. In particular, syndesmosis screws are known to break and are recommended to be removed. There is some discussion as to the correct timing of their removal. Hence, the removal of the syndesmosis screws and hardware is supported by medical necessity within the literature, and a course of physical therapy after such removal is reasonable and medically necessary. As mentioned previously, based upon ODG Guidelines and medical experience, we would find the surgical fees for removal of the hardware to be medically necessary and the postoperative visits to control the patient subsequent to the surgery. As far as physical therapy is concerned, most physicians will wait approximately two weeks prior to going ahead with physical therapy, and hence, six weeks of therapy three times a week would be reasonable and medically necessary. Hence, any physical therapy that occurred between 03/27/07 and 05/27/07 would be reasonable, medically necessary, and related to the required hardware removal. Physical therapy outside of that period would not be supported by ODG Treatment Guidelines.

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)