



Notice of Independent Review Decision

DATE OF REVIEW: 3/5/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for 12 additional visits of physical therapy to the left ankle.

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

Texas Licensed 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)

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.

The previously denied request for 12 additional visits of physical therapy to the left ankle.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Confirmation of Receipt of a Request for a Review dated 2/26/08.
- Request Form dated 2/22/08.

- Notice to CompPartners dated 2/27/08.
- Notice to Utilization Review Agent of Assignment dated 2/27/08.
- Physician Determination –Initial dated 2/12/08.
- Therapy Referral dated 1/30/08.
- Denial of Reconsideration of Pre-Authorization or Concurrent Review Request dated 2/25/08, 2/15/08.
- Pre-Authorization Request Form dated 2/22/08, 2/14/08, 2/11/08.
- PT Daily Progress Note dated 1/28/08, 1/30/08, 1/25/08, 1/23/08, 1/21/08, 1/17/08.
- Work Status Report dated 2/5/08, 1/30/08, 12/28/07, 11/16/07, 10/17/07.
- Notice to Utilization Review Decision dated 1/20/08.
- Left Ankle MRI dated 11/9/07.
- Evaluation dated 12/5/07, 11/16/07, 10/31/07, 10/17/07.

No guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Twisted his left ankle when he stepped out of a truck.

Diagnosis: Ligamentous sprain of the left ankle joint with pain/tenderness.

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

This xx year old male sustained a left ankle sprain on xx/xx/xx , when he stepped out of a truck and twisted his ankle. The claimant was treated with immobilization and crutches. An MRI of the left ankle on 11/09/07, demonstrated chronic tears of the anterior talofibular ligament, posterior talofibular ligament, and calcaneofibular ligament. There was tenosynovitis of the peroneal tendons and tendinosis of the peroneal longus tendons. There was also tenosynovitis of the posterior tibial tendon with tendinitis and tenosynovitis of the flexor tendons. There was a small ankle joint effusion with small intraarticular bodies projecting posteriorly and layering with the flexor hallucis longus tendon sheath. On 11/16/07, Dr. noted that the claimant was off crutches but still had significant pain and tenderness. Immobilization was continued. Stress views of the ankle showed no abnormal talar tilt. The claimant began physical therapy in mid January 2008. Therapy notes indicated that the claimant was making appropriate progress. Dr. note of 01/30/08, documented better flexibility, range of motion and strength. The claimant had some clicking and popping in the ankle and some crepitation was noted. Additional therapy was requested and denied on two prior peer reviews. Based on review of the records, additional therapy is not recommended. The claimant has completed 12 visits of therapy with good progress. The Official Disability Guidelines (ODG) recommend nine therapy visits for an ankle sprain. The claimant has exceeded the recommended amount of therapy per ODG guidelines and has made good progress. There was no clinical

information beyond the end of January 2008, which would have been mid way through his initial therapy program. There was no objective information to support the need for additional therapy for this diagnosis. A home exercise program should be sufficient for progression of his ankle strength and motion.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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. – Treatment in Workers' Comp 2008 Updates, Ankle and Foot: Physical Therapy.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).