



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 03/12/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy twice a week for six weeks to include CPT codes 97110, G0283, 97035, 97140, and 97033

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Foot and Ankle 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)

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.

Physical therapy twice a week for six weeks to include CPT codes 97110, G0283, 97035, 97140, and 97033 - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 01/22/08 and 02/12/08

An evaluation with P.T. dated 01/29/08

Letters of non-certification, according to the ODG, from The dated 02/04/08 and 02/12/08

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 01/22/08, Dr. recommended physical therapy, an ASO brace, and possible surgery. On 01/29/08, Mr. recommended physical therapy twice a week for six weeks. On 02/04/08 and 02/12/08, The wrote letters of non-certification for the physical therapy. On 02/12/08, Dr. again recommended physical therapy and continued use of an ASO brace.

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

I do believe that this is a very fundamental and main therapeutic modality that is required initially for chronic instability of the ankle after noted significant inversion injury, especially when there has been an MRI scan that documents abnormalities to these lateral-sided ligaments and interosseous ligament and also when there is reported documentation on the chart of very minimal amount of physical therapy. Considering the only alternative at this particular point is a surgical reconstruction of the lateral ligaments such as a modified or Brostrom ligamentous reconstruction, often times with a very dedicated individual as well as knowledgeable, dedicated therapist in conjunction with the treating physician, the patient can significantly improve the strength and functional abilities of the ankle such that operative reconstruction is not required. This is a mainstay of chronic lateral instability if there is noted to be significant peroneal weakness and an incomplete physical therapy program in the past or none at all.

With a knowledgeable patient that is considerably motivated, this sometimes can be done and monitored by the treating physician. Often times it is much more constructive and beneficial for there to be professionally guided physical therapy, and a home exercise program is instituted during that therapy to supplement the treatment and rehabilitation.

In short, a maximized, conservative, non-operative regimen such as physical therapy should be considered and monitored by her treating physician as an

initial attempt at return to a prefunctional injury level. Therefore, physical therapy twice a week for six weeks to include CPT codes 97110, G0283, 97035, 97140, and 97033 would be reasonable and necessary.

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 AND KNOWLEDGE BASE
- 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)