Advanced Medical Reviews

ACCREDITED EXTERNAL REVIEW

Notice of Independent Review Decision

DATE OF REVIEW: 9/5/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1. Physical Therapy 07/15/08 and 06/20/08.

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from Illinois College of Podiatric Medicine. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Podiatry since 1979.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

1. Physical Therapy 07/15/08 and 06/20/08.
   Upheld

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a xx year old male injured employee who presents with an injured left foot. He is post surgery and complains of pain across the left sub second MPJ and fibular sesamoid. The provider is requesting physical therapy.

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

The injured worker has received extensive P.T. without achieving noticeable improvement. He remains at 6/10 pain rating (subjective) as noted by physical therapist. There is a significant amount of discussion by the physical therapist about pain associated with the AFO device and accommodations needed for comfort. P.T. is for muscle strengthening, once the exercises are taught this becomes home therapy. According to the ODG Guidelines, physical therapy (one to five visits) to teach patient range-of-motion and muscle-strengthening exercises may be needed after cast removal. The P.T. should be home therapy at this point. The request for additional physical therapy is not medically necessary and therefore the previous denial is 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
X 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)