

US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 3, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

PT 3x6 BLE with 97010, 97110, 97112, 97140, 97012, 97014, 97035, 97033

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

MD, 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)

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 reviewer finds that medical necessity exists for PT 3x6 BLE with 97110 and 97140.

The reviewer finds that medical necessity does not exist for PT 3x6 BLE with 97112, 97012, 97014, 97035, 97033 and 97010.

Injury Date	Review Type	CPT Code	Service Units	Upheld/Overturned
	Prospective	97110	18	Overturned
	Prospective	97140	18	Overturned

	Prospective	97012	18	Upheld
	Prospective	97014	18	Upheld
	Prospective	97035	18	Upheld
	Prospective	97033	18	Upheld
	Prospective	97010	18	Upheld
	Prospective	97112	18	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Peer review, Dr, 12/15/08
Peer review, Dr., 12/22/08
ODG Guidelines and Treatment Guidelines
CT LE, 08/25/07
X-rays foot, 08/25/07
Operative report, Dr., 08/26/07
Right ankle X-rays, 8/26/07
Operative report, Dr., 09/11/07
Discharge Summary, 09/16/07, 11/21/07
Tibia two views, 09/17/07
Office note, Dr., 09/24/07, 01/24/08
Office note, Dr., 10/01/07, 12/03/07, 12/10/07, 12/21/07, 01/02/08, 01/10/08, 01/18/08, 01/30/08, 02/07/08, 03/31/08, 04/23/08, 05/14/08, 08/29/08, 10/20/08, 11/05/08, 11/19/08
CXR report, 10/02/07
Laboratory results, 10/02/07
Letter, Dr., 10/04/07
Operative report, Dr., 10/08/07, 10/10/07, 10/12/07, 10/18/07
PICC line, 10/08/07
Operative report, Dr., 10/12/07, 01/03/08, 05/22/08, 07/22/08, 10/09/08
Laboratory values, 10/18/07
X-ray abdomen pelvis, 10/19/07
Letter, 10/20/07
H&P, 11/07/07
Inpatient physical and occupational therapy notes, 11/19/07 to 11/21/07
Office notes, Dr. 06/12/08, 09/09/08
CT scan, 07/10/08
CT lower extremity, 09/29/08
Prescription for PT, Dr., 12/03/08
PT evaluation, 12/10/08
Letter, Physical Therapist, 12/16/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old male who sustained crush injuries to his bilateral extremities on xx/xx/xx. The claimant underwent bilateral open reduction internal fixation to the lower extremities on xx/xx/xx. An Ilizarov external fixator was placed on 10/12/07. On 01/03/08, application of Ilizarov external fixator of the left tibia and removal of previous

Ilizarov external fixator to the left tibia was done. On 01/10/08, Dr. recommended physical therapy and full weight bearing for the left and non weight bearing on the right. On 03/31/08, Dr. recommended full weight bearing on the right. Dr. noted that the right lower extremity was well healed 06/12/08. On 10/09/08, removal of Ilizarov external fixator to the tibia was performed. Dr. evaluated the claimant on 10/20/08 and recommended serially casting on the left to get his ankle and foot back up to neutral position. The claimant was allowed to fully weight bear in his cast. Physical therapy was recommended for full weight bearing as tolerated and for knee range of motion. Dr. evaluated the claimant on 11/05/08. Dr. noted that his x-rays looked fantastic and his soft tissues were great. The tibia on x-rays looked solidly healed. There was a little apex posterior granulation but Dr. felt this would bring the ankle into neutral position. Dr. noted on 11/19/08 that the cast would be removed in 2 weeks. On 12/03/08, Dr. recommended physical therapy for gait training, weight bearing, range of motion and modalities for the bilateral extremities. The 12/10/08 physical therapy evaluation noted that the claimant had completed 9 physical therapy visits. Active range of motion for the right ankle was 67 degrees of plantar flexion, -22 degrees of dorsiflexion, 30 degrees of inversion and eversion was 70 degrees. Left ankle plantar flexion was 37 degrees, dorsiflexion was -4 degrees, inversion was 30 degrees and eversion was 50 degrees. The claimant reported pain with ambulation. The 12/16/08 physical therapy letter note indicated that therapy for the left leg had been limited to general strengthening of the quad and hamstrings due to restrictive presence of external fixator followed by casting.

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

The reviewer finds that medical necessity exists for PT 3x6 BLE with 97110 and 97140. The patient meets the criteria established in the ODG.

- 97110 Therapeutic exercises and treatment for strength and movement recovery
- 97140, manual therapy-Recommended. Exercise program goals should include strength, flexibility, endurance, coordination, and education. Patients can be taught to do early passive range-of-motion exercises at home by a physical therapist. (Colorado, 2001) See Physical therapy for recommended number of visits if exercise training is prescribed.

ODG recommends 30 visits of therapy and additional therapy can be recommended if there are extenuating circumstances and progress with therapy per the ODG Preface.

The reviewer finds that medical necessity does not exist for PT 3x6 BLE with 97112, 97012, 97014, 97035, 97033 and 97010. (Traction, NMES, ultrasound, electrical stimulation, and iontophoresis) There is a lack of support for these modalities.

- 97010, hot/cold packs- Under study. Ice works better than heat to speed recovery of acute ankle sprains. Range-of-motion improvement may be greater after heat and stretching than after stretching alone.

- 97112, therapeutic procedure; neuromuscular education- Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain
- 97012 traction- not addressed in ODG
- 97014, ultrasound -Not recommended. Therapeutic ultrasound is no more effective than placebo in the treatment of plantar heel pain. (Crawford, 1996) There is little information available from trials to support the use of many physical medicine modalities for treating disorders of the ankle and foot. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated.
- 97035, estim-Not recommended. Considered investigational for all indications. Galvanic stimulation is characterized by high voltage, pulsed stimulation and is used primarily for local edema reduction through muscle pumping and polarity effect. Edema is comprised of negatively charged plasma proteins, which leak into the interstitial space. The theory of galvanic stimulation is that by placing a negative electrode over the edematous site and a positive electrode at a distant site, the monophasic high voltage stimulus applies an electrical potential which disperses the negatively charged proteins away from the edematous site, thereby helping to reduce edema.
- 97033. iontophoresis Not recommended. There is limited evidence for the effectiveness of topical corticosteroid administered by iontophoresis in reducing plantar heel pain.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, foot and ankle
 ODG **Fracture of tibia and fibula** (ICD9 823)

Medical treatment: 30 visits over 12 weeks

Post-surgical treatment (ORIF): 30 visits over 12 weeks

Fracture of ankle (ICD9 824):

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment: 21 visits over 16 weeks

Fracture of ankle, Bimalleolar (ICD9 824.4):

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment (ORIF): 21 visits over 16 weeks

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)**