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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy x 12 visits (97110, 97140, 97112)

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management

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)

PATIENT CLINICAL HISTORY SUMMARY

This xx-year old woman sustained second-degree burns on the anterior aspect of her right ankle on xx/xx/xx. She is diabetic. She had a scar excision on 3/7/08 with a graft on 12/3/08. She received 30 sessions of postoperative physical therapy beginning in February 2009. She was felt to be at MMI. Dr. wrote on 5/28/09 that she had restricted motion of 15 degrees of dorsiflexion, 35 of plantarflexion, 25 of inversion and 15 degrees of eversion.

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

Records indicate this woman has some ongoing pain in the ankle. The ranges of motion provided by Dr. were for the involved side, but not of the contralateral ankle for comparison. AMA Guides 4th edition for "normal values" accepts any dorsiflexion greater than 10 degrees, plantar flexion more than 20 degrees, inversion more than 25 degrees and eversion more than 10 degrees, as normal. She had already been determined as being at MMI. She had some residual restrictions of eversion. The ODG addresses the need for the range of motion after surgery. It recommends 16 sessions over 8 weeks. She had 30 sessions and an additional 12 are now requested. There was no information provided to support the need for the additional therapies beyond those described in the ODG. The request exceeds the recommendations in the ODG. The reviewer finds that medical necessity does not exist for Physical Therapy x 12 visits (97110, 97140, 97112).

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

ACOEM-AMERICA 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)