

SENT VIA EMAIL OR FAX ON
May/26/2009

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311
Email: rm@independentresolutions.com

DATE OF REVIEW:

May/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 additional visits of PT 3 X 4 for the right ankle

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

CT right ankle, 09/18/08

Doppler, 09/23/08

X-ray, 09/26/08

PT request, 11/20/08

PT evaluation, 12/02/08

PT notes, 12/11/08, 12/18/08, 02/03/09, 02/24/09, 03/03/09

PT approval, 01/30/09

X-ray right ankle, 03/16/09

Notes, Mutual, 03/27/09, 04/09/09

Office note, Dr. 09/28/08

Office notes, PA-C, 09/26/08

12/04/08, 01/30/09

Therapy Treatment Logs, 2008, 2009

Prescription, 01/27/09, 03/16/09

Therapy, 02/10/09, 02/17/09

MRI, 03/26/09, 05/01/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male injured on xx-xx-xx when he fell. He had a comminuted fracture of the distal tibia that was treated with open reduction and internal fixation on or about 09/26/08.

On 12/02/08, therapy was initiated. Dorsiflexion was to neutral and plantar flexion was 30 degrees. The neurovascular status was intact. Strength was 3/5. A 12/18/08 note indicated the claimant was progressing weight bearing but he remained in his boot.

Additional therapy three times a week for six weeks was recommended and approved on 01/30/09. The 02/03/09 therapy report indicated the claimant was referred back due to ongoing ankle pain. The claimant was wearing a work boot. Dorsiflexion was 7 degrees, planar flexion 45 degrees, inversion 20 degrees and eversion 10 degrees. The scar was hypersensitive and there was some weakness.

Therapy reports on 02/24/09 and 03/03/09 showed dorsiflexion was 5 degrees, plantar flexion 50 degrees, inversion 30 degrees and eversion 10 degrees. Additional therapy was requested. A 03/16/09 x-ray of the right ankle reported that the fracture line was difficult to see and a CT was possibly indicated. There was an opaque foreign body posterior to the calcaneus that was a pin or needle.

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

Twelve additional physical therapy visits, three times a week for four weeks to the right ankle is not medically indicated and appropriate after undergoing open reduction internal fixation of the ankle 09/2008. This is following a 09/15/08 fall from scaffolding.

Postsurgical treatment, per ODG, states 21 visits over 16 weeks. There have been 30 visits to date thus far. There is no notation that the physical therapy is necessary or any complication noted on the chart. This is outside the standards of ODG.

Official Disability Guidelines Treatment in Worker's Comp 2009 Ankle and Foot-Physical Therapy, ODG Prefac

Fracture of ankle (ICD9 824)

Medical treatment: 12 visits over 12 week

Post-surgical treatment: 21 visits over 16 weeks

When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.

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)