

SENT VIA EMAIL OR FAX ON
Oct/12/2009

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/12/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 3 X wk X 6 wks

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

Office notes, Dr., 3/2/09, 04/01/09

OR report, Dr., 3/19/09

Office notes, 5/13/09, 06/29/09

PT notes, 7/1/09, 07/06/09, 07/08/09, 07/10/09, 07/13/09, 08/03/09, 08/05/09, 08/07/09, 08/10/09, 08/19/09, 08/21/09

Appointment cancellation, 7/3/09

X-ray, 8/14/09

Peer review, Dr., 8/24/09

Peer review, Dr. , 9/14/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained a left comminuted calcaneal fracture in a ten-foot fall on xx/xx/xx. On 03/19/09, the claimant underwent open reduction and internal fixation with no noted complications. He remained non-weight bearing for at least four weeks before beginning physical therapy. A previous review dated 08/24/09 noted the claimant completed eighteen therapy sessions. The brief therapy notes provided continued to indicate good progress with no objective measurements of functional improvements. An x-ray on 08/14/09

showed mild flattening along inferior margin, and a small inferior calcaneal spur, with increased density in the central calcaneus likely callus formation and postoperative change. Continued therapy, three times a week for six weeks was requested and non-certified on two separate occasions. The request was submitted for review.

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

The request for treatment in this case when added to the previously provided physical therapy treatments would certainly far exceed the guidelines. Such a lengthy course of therapy is not well supported by the records provided. The Reviewer would agree with the prior determination in this case.

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)