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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 04/29/2010

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified) doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient physical therapy two (2) times a week for four (4) weeks consisting of manual therapy, therapeutic exercise neuromuscular reeducation, electrical stimulation (e-stim) and ultrasound as related to the left ankle for no more than 4 units per session.

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o xx/xx/xx ER Nurses Worksheet, Physician's notes and ER Report from Dr.
- o xx/xx/xx Employee's Report of Injury signed by the Claimant
- o xx/xx/xx Left foot x-rays read by Dr.
- o 05-26-09 Initial examination report from Dr.
- o 06-05-09 Daily PT notes from, PT
- o 06-18-09 Medical Report from Dr.
- o 06-23-09 Notice of Disputed Issue(s) - Low Back -
- o 07-01-09 Daily PT notes from, PT
- o 07-06-09 PT notes from, PT covering 12 visits through August 31, 2009
- o 07-09-09 Left ankle MRI read by Dr.
- o 09-01-09 Medical report from Dr.
- o 09-08-09 Left leg sonogram read by Dr.
- o 09-23-09 Designated Doctor Examination from Dr.
- o 09-24-09 Medical Report from Dr.
- o 10-13-09 Medical Report from Dr.
- o 10-16-09 MRI lumbar spine read by Dr.
- o 10-20-09 Medical Report from Dr.
- o 11-03-09 PT assessment report from, PT
- o 11-23-09 Daily PT notes from, PT covering 6 visits through 12-15-09
- o 12-16-09 PT reassessment report from, PT

- o 12-17-09 Medical Report from Dr.
- o 12-22-09 Daily PT Notes covering four visits through 01-04-10 from , PT
- o 01-08-10 Designated Doctor Examination from Dr.
- o 01-14-10 Medical Report from Dr.
- o 02-01-10 PT Progress Report from, PT
- o 02-03-10 PT Progress Report from, PT
- o 03-02-10 Initial Adverse Determination letter
- o 03-11-10 Medical Report from Dr.

- o 03-11-10 Script for PT from illegible
- o 03-15-10 Initial Evaluation from, PT
- o 03-17-10 Fax request for authorization for PT 3 x 4 from Dr.
- o 03-24-10 Adverse Determination letter for Reconsideration
- o 04-07-10 Request for IRO from the Claimant
- o 04-09-10 Confirmation of Receipt of Request for IRO from TDI
- o 04-12-10 Notification of Case Assignment from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury to the left ankle and left side on xx/xx/xx. The ER notes state "he went to stand up at work yesterday and heard a popping noise from the foot." He felt a popping noise to the bottom of the foot and developed pain while trying to stand up and applying pressure on his left foot. The patient is 6 feet and 350 pounds. Left ankle x-rays were taken on May 13, 2009 and showed no evidence of acute bone injury or disease. Left ankle MRI was performed July 9, 2009 and showed no fracture or ligament tear. Slight tendinosis of the achilles and posterior tibial tendons. Slight insertional tendinosis of the achilles tendon without tear. The plantar fascia is intact. He was diagnosed with a foot sprain.

On May 26, 2009 the patient came under the care of his current orthopedic provider. He was examined for left ankle and low back pain. He was determined to have a lumbar sprain and a tear of the plantar fascia and was given a boot. He was to use crutches. Lumbar MRI was recommended.

He attended PT in June 2009. PT notes of June 5, 2009 note the patient has zero pain but gets pain of 5/10 with prolonged sitting or standing. The PT diagnosis states low back pain and neck pain, muscle disuse atrophy and disc displacement. There is no mention of the foot or ankle and therapy is applied to the cervical spine and low back. The referring doctor is not the current orthopedic provider.

The patient was reexamined 6 weeks post injury. He is now "going into a pain behavior mode with significant complaints about discomfort and pain in his lower back because of inability to walk." "So far, the patient has not received any treatment whatsoever." He is using crutches. He states at one point he was unable to get up and his father almost took him to the emergency room. He has a lumbar sprain and plantar fascial fibromatosis. Recommendation is for lumbar MRI.

PT notes of July 1, 2009 indicate the patient is being provided mobilization to the neck and low back. He has been feeling better, rating his pain as 5/10. There is no mention of an ankle/foot condition.

PT notes covering 12 sessions of land-based and aquatic therapy covering the period of July 6, 2009 through August 31, 2009 are reviewed: The first three visits do not mention a foot or ankle condition but describe treatment for the neck and back. On July 17, 2009 the patient appears to begin pool exercises and was able to enter and exit the pool independently via the ladder. Beginning this date, ankle sprain is added to the diagnoses. On July 27, 2009 the patient reports more pain in his neck and back. The first mention of ankle pain occurs on the visit of August 5, 2009. He rates his ankle pain as 5/10. He states he is feeling better and is taking less medication. On August 20, 2009 the patient states he is not having any pain. On August 25, and August 31, 2009 he is having more pain in the ankle rating his pain as 5/10. He does pool and land-based exercises and is noted to have swelling at the ankle.

Left ankle MRI was performed on July 9, 2009 and showed mild insertional tendinosis of the posterior tibial tendon and achilles tendon.

At reevaluation on September 1, 2009 the patient is noted to be making very slow progress in therapy. He complained bitterly about his low back. He complains that his employer is calling him a liar, etc. There is restricted motion and the ankle and some swelling over the calf muscle. DVT was considered and needed to be ruled out. The low back has not yet been determined to be a compensable injury.

A possible venous condition was ruled out via sonography on September 8, 2009.

The patient attended a Designated Doctor Examination on September 23, 2009. The patient attended PT in June 2009. He states he attended 12 sessions which were helpful. Modalities had not been approved and a lumbar MRI was denied. He was walking with crutches. He reports pain at the bottom of the foot and swelling in the calf in the AM and pain in his calf radiating toward his toes. He notes pain with walking and the therapist noted an antalgic limp. He is using Darvocet and naproxen. He demonstrates a mild left-sided limp. The ankle is stable. There is mild tenderness to palpation over the medial and lateral ankle and achilles

region. There is moderately severe tenderness to palpation of the sole of the left foot over the plantar fascia. ROM of the ankle is restricted in all planes. Motor strength and sensation are intact. July 9, 2009 ankle MRI showed mild insertional tendinosis of the posterior tibial tendon and achilles tendon. Tenderness was noted in the left lower back. Left straight leg raise was remarkable for

low back pain at 90 degrees. Neurologic functions are normal. Diagnosis is plantar fasciitis on the left, lumbar strain, rule out left-sided radiculopathy, left calf swelling of undetermined etiology with ultrasound results pending. A lumbar MRI was supported. The lumbar condition is related to the injury.

The patient was seen next on September 24, 2009. The patient has sustained an industrial injury with a severe ankle sprain. He had been sent for therapy modalities; however, over the past month, he did not receive any PT. Last visit he was found to have significant swelling, discomfort and pain at the calf and was sent for a venous doppler which turned out to be negative. He has tenderness at the ankle and some swelling at the leg. Diagnosis is sprain of the calcaneofibular ligament. Additional PT is recommended.

At reevaluation on October 13, 2009 the provider notes the low back has been accepted as part of the patient's injury. The patient reports significant low back pain and can flex only slightly and not extend at all. X-rays are essentially normal. Recommendation is for lumbar MRI. Lumbar MRI was performed and noted on the October 20, 2009 report to show evidence of spondylosis without an acute disc injury. His diagnosis remains ankle and low back sprain.

Lumbar MRI was performed on October 16, 2009 and interpreted to show mild scattered degenerative endplate changes to the bone marrow, scattered Schmorl's nodes formations, a mild disc bulge at L5-S1 without significant spinal canal stenosis or foraminal narrowing and otherwise no evidence of intra or extrathecal masses or mass effect and unremarkable surrounding paravertebral soft tissues.

The patient was assessed in PT on November 3, 2009 for low back pain of 3 weeks duration. His physician told him it is secondary to his ankle pain. He was told he has muscle spasms in his back. He reports symptoms into the left leg and a pain level of 5/10 with medication. He is not working. Muscle tightness is noted in the lower extremity. Strength deficits are noted carrying from 3/5 to 4-/5 in the major lower extremity muscle groups. Flexion is to 18 degrees and extension to 5 degrees. He has poor posture and weak trunk muscles. 18 sessions are planned of passive modalities and active exercises.

PT notes are reviewed covering November 23, 2009 through December 15, 2009, six sessions: He has tightness in the lumbar paraspinals and limited lower extremity flexibility. He did fairly well with exercises (11-23-09). He states he has less pain today. He rates his pain as 5/10 (11-25-09). He states he has more pain today and continuing left leg numbness (11-30-09). He was instructed to do extension exercises at home (12-09-09). He reports a pain level of 4/10. He has improved in LE flexibility (12-11-09). He has difficulty with sleeping due a feeling of restless leg in the right leg. He is improving on quad and hamstring flexibility (12-15-09). The diagnoses do not include the ankle for these visits.

The patient was reassessed in PT on December 16, 2009. He still has ankle pain with weightbearing. His ankle pain increases with walking, standing, rising from sitting and lifting things. He reports low back pain and stiffness. Active ankle dorsiflexion has been improved to 8 degrees. Ankle motion to 11 degrees has not been met. Ankle strength goal has not been met. He is deconditioned due to lapse in therapy for his ankle. Recommendation is for an additional 12 visits of PT for the ankle.

The patient was reevaluated on December 17, 2009. His chief complaint is lower back pain and extremity pain. He has had "about three or four sessions of therapy." He complains about persisting back and ankle pain and making slow progress. He is not ready to return to work. Recommendation is for additional therapy and occasional Vicodin.

PT Daily Notes covering four additional visits from December 22, 2009 through January 4, 2010 are reviewed. The PT diagnoses do not include the ankle. The notes do not indicate any treatment to the ankle. He rates his pain as 4/10 (12-22-09). He has more back pain from running errands. He reports a pain level of 8/10 (12-23-09). His back is feeling better with less tightness (12-28-09). He is feeling better and rates his pain as 2/10. He was instructed to do HEP every other day while additional therapy is being requested (01-04-10).

The patient returned to the Designated Doctor on January 8, 2010. Records of September 1, 2009 note very slow progress in therapy. On September 24, 2009 he was noted to have a negative Doppler for DVT. He diagnosis remained severe ankle sprain. Lumbar MRI of October 16, 2009 showed mild scattered degenerative endplate changes; a mild disc bulge at L4-5 with mild spinal canal stenosis and mild bilateral foraminal narrowing; and a mild disc bulge at L5-S1 without stenosis. The imaging quality was degraded and grainy. When seen on October 20, 2009 he was recommended medication and additional therapy. He had 9 sessions of PT, which he indicates were beneficial for his ankle and low back and left leg pain. Straight leg raise is positive for low back pain at 60 degrees. Left ankle dorsiflexion shows mild weakness of 4/5. Diagnosis is left ankle sprain, left plantar fasciitis, lumbar sprain superimposed upon degenerative disc disease at L4-5 and L5-S1 and left-sided radicular symptoms. He is not at MMI. ODG supports 12 PT visits for his diagnosis. He warrants perhaps a few more than 12.

The patient's orthopedic provider reevaluated him on January 14, 2010. He had a few sessions of therapy and it is helping him. This is the first time he is showing good response. On examination, the patient has continued obesity, complaints about discomfort and pain in the ankle, slight instability of the ankle and low back pain. He has a calcaneofibular sprain and back sprain. 12 additional sessions of PT were recommended.

According to the PT progress report of February 1, 2010 the patient reports doing better with therapy. He is able to perform HEP and reports a pain level of 2/10 at the ankle and 3/10 at the low back. Active ankle dorsiflexion is 0 and plantar flexion 45 degrees (normals = 50/25/35). Lower extremity strength is 4+/5. Core strength and stabilization still have room for improvement. Plan is for additional PT for core strengthening, lower extremity strength and flexibility and to improve ankle ROM of 2 x 4.

The patient was reassessed in PT on February 3, 2010. He is having less pain. He describes feelings of small pinches. Pain is greatest on awakening. He feels tingling in the leg at least once a week. He has lost 18 pounds and feels a reduction in pressure in his back as well. Hamstring stretch is good to 60 degrees. Flexion is to 60 degrees and extension to 15 degrees. Dorsiflexion strength is 4-/5 bilaterally. Recommendation is for additional PT of 1x week for 5 weeks. He still has instability of the lumbar, evident with pain with quick movements and transferring in from positions. He has decreased strength of the core and lower extremity muscles and some loss of lower extremity flexibility.

On February 11, 2010 the provider noted the patient's ankle pain has resolved. His back is still an issue and three or four more weeks of therapy should suffice.

Request for additional outpatient physical therapy two (2) times a week for four (4) weeks to the left ankle with modalities was considered in review on March 2, 2010 with recommendation for non-certification. The patient has a diagnosis of ankle/foot pain, plantar fasciitis, abnormal gait, low back pain with spasm, lumbar sprain, muscle weakness and left foot sprain. He has attended 13 sessions of PT. On examination ankle ROM and strength were noted diminished. ODG supports up to 9 visits for the patient's ankle diagnosis. ODG recommends fading of treatment and transition to HEP. The request is not supported.

The patient was reassessed by his physician on March 11, 2010 for low back and lower extremity pain. He has a disc injury and radiating pain. Therapy has not been approved over the last 8 weeks. Straight leg raising is positive. His neurovascular and motor exam are unremarkable. Diagnosis is lumbar sprain and lumbar disc displacement. He wants to go to another therapy facility where they will pay more attention to him. Eight additional sessions of therapy were recommended.

The patient was assessed in PT at a new facility on March 15, 2010. He was provided 12 weeks of therapy, mostly for the foot. He reports about 9 sessions for the low back. He had good relief, but has not had therapy since July 2009 (sic). He is using hydrocodone. He reports a pain level of 3-7/10. He reports some radiation of pain into the left lower extremity and continued swelling in the foot and ankle. A medical note dated October 20, 2010 notes x-rays are negative. Another note states, MRI shows evidence on spondylosis, mild disc bulging, however no slipped disc or pressure on the nerve roots. Active flexion is 75% of normal and extension 10% of normal. Reflexes are intact. Straight leg raise is negative. He states he has not had any aquatic therapy or traction. The Designated Doctor recommended he continue with some additional therapy. Generally he has some limitations in ROM, tightness of the trunk and LE musculature and limited function. He is recommended to attend 8 sessions. Therapy will include modalities therapeutic exercises and aquatic exercises. ODG supports 10 visits of PT over 5 weeks for sprains of the back. The patient's ankle condition is not mentioned.

Request for reconsideration, additional outpatient physical therapy two (2) times a week for four (4) weeks to the left ankle with modalities was considered in review on March 24, 2010 with recommendation for non-certification. The initial diagnosis was left foot sprain and left plantar fascia fibromatosis. The current examination is dated February 1, 2010. He has attended 13 visits of PT. None of the appeals correspondence addresses any of the issues raised by the initial review. In fact, the appeals correspondence exclusively mentions treatment of the lumbar spine, which was not part of the original request.

Request was made for an IRO.

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

ODG supports 9 visits of PT over 5 weeks for sprains of the ankle.

Initially, the patient went to stand up and when he put weight on his foot he heard a popping noise from the foot and experienced foot pain. He was not pushed. He did not fall. He did not twist his ankle. The patient is obese with a BMI of 47.5 and is deconditioned. Imaging showed slight insertional tendinosis of the achilles and posterior tibial tendons. He developed low back pain, which eventually was accepted as part of the injury.

He came under orthopedic management and was given a diagnosis of lumbar sprain and plantar fascial fibromatosis. He attended 12 visits of PT from July 6, 2009 through August 31, 2009, mostly for his neck and low back but also for his ankle. He was able to use the pool ladder without difficulty for pool exercises. A possible venous condition was ruled out via sonography on September 8, 2009.

At the end of September 2009 the diagnosis was updated to sprain of the calcaneofibular ligament. Additional PT was recommended. The patient re-entered PT and attended six sessions from November 23, 2009 through December 15, 2009 for the low back. His ankle condition is not mentioned in the PT notes. On December 16, 2009 the patient is assessed again in PT and

is recommended 12 additional visits for the ankle. On December 17, 2009 the orthopedic provider states, he has had about three or four sessions of therapy. Additional therapy is recommended. The patient again re-enters PT and attends an additional four visits during the period of December 22, 2009 through January 4, 2010. The PT Daily Notes do not include a diagnosis pertaining to the ankle and no treatment appears to have been provided to the ankle. On January 14, 2010 the provider states he has had a few sessions of therapy and recommends an additional 12 sessions. Back in therapy on February 1, 2010 the patient reports ankle pain of 2/10 and low back pain of 3/10. His ankle ROM is returning to normal (plantarflexion is 45/50 degrees, inversion 20/25 degrees and eversion 10/35). The therapist recommended 8 more sessions.

The provider reassessed the patient on February 11, 2009 and reported, "the patient's ankle pain has resolved. His back is still an issue and three or four more weeks of therapy should suffice." On March 11, 2010 the provider noted some persisting low back pain and recommended additional PT for the low back. The patient is sent to a new PT facility where he is assessed on March 15, 2010 for his residual low back complaints. The patient is incorrectly reported to not have attended any aquatic therapy and he is recommended more visits for the low back. The ankle is not mentioned.

The first-line reviewer notes the recommended amount of PT for the patient's diagnoses have been exceeded.

The second-line reviewer notes none of the appeals concern the patient's ankle which is the original injury and the subject of the review.

The patient has attended 23 visits of PT, some for his neck, some for his back and some for his ankle. On February 11, 2009 the provider reported the patient's ankle pain has resolved and sent the patient to a new facility for PT for the low back. There is no current ankle condition per the provider and there is no current concern by the new therapist for an ankle condition. The patient has benefited from at least 9 visits of therapy to the ankle with apparent resolution of his ankle injury. Additional therapy to the ankle is not medically indicated at this time.

Therefore, my recommendation is to agree with the previous non-certification for outpatient physical therapy two (2) times a week for four (4) weeks consisting of manual therapy, therapeutic exercise neuromuscular reeducation, electrical stimulation (e-stim) and ultrasound as related to the left ankle for no more than 4 units per session.

The IRO's decision is consistent with the following guidelines:

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

The Official Disability Guidelines 03-26-2010 Ankle and Foot Chapter - Physical Therapy:

Recommended. Exercise program goals should include strength, flexibility, endurance, coordination, and education. Patients can be advised to do early passive range-of-motion exercises at home by a physical therapist. See also specific physical therapy modalities by name. This RCT supports early motion (progressing to full weightbearing at 8 weeks from treatment) as an acceptable form of rehabilitation in both surgically and nonsurgically treated patients with Achilles tendon ruptures.

ODG Physical Therapy Guidelines -

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Ankle/foot Sprain (ICD9 845):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 34 visits over 16 weeks

Plantar Fasciitis (ICD9 728.71):

6 visits over 4 weeks