

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: March 22, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy three times a week for four weeks. CPT Codes: 97110, 97140 and 97112.

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

AMERICAN BOARD OF ORTHOPAEDIC SURGEONS

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

Medical records from the Carrier include:

- Texas Workers' Compensation Work Status Report, 06/30/10, 08/20/10, 09/22/10, 11/12/10, 01/28/11
- M.D., 06/30/10
- Orthopedics and Sports Medicine, 07/21/10, 08/20/10, 10/12/10, 11/03/10, 11/12/10, 12/15/10, 12/30/10, 01/20/11, 01/28/11, 02/25/11
- Orthopedics and Sports Medicine Physical Therapy, 11/30/10, 12/02/10, 12/06/06, 12/10/10, 01/03/11, 01/05/11, 01/12/11, 01/19/11
- D.C., 02/28/11

Medical records from the URA include:

- Official Disability Guidelines, 2008

- Orthopedics and Sports Medicine Physical Therapy, 11/12/10, 11/23/10, 11/24/10, 11/30/10, 12/02/10, 12/06/06, 12/10/10, 12/14/10, 12/15/10, 12/20/10, 21/21/10, 12/30/10, 01/03/11, 01/05/11, 01/10/11, 01/12/11, 01/19/11
- Orthopedics and Sports Medicine, 11/12/10, 12/15/10, 01/20/11, 02/22/11, 02/25/11,
- 02/28/11, 03/01/11, 03/09/11

Medical records from the Provider include:

- Orthopedics and Sports Medicine Physical Therapy, 11/12/10, 11/23/10, 11/24/10, 11/30/10, 12/02/10, 12/06/10, 12/10/10, 12/14/10, 12/15/10, 12/20/10, 12/21/10, 12/30/10, 01/03/11, 01/05/11, 01/10/11, 01/12/11, 01/19/11
- Orthopedics and Sports Medicine, 11/12/10, 12/15/10, 01/20/11

PATIENT CLINICAL HISTORY:

The patient is a female employee of the who on or around xx/xx/xx, sustained a supination and lateral rotation injury of her right ankle.

The patient has been seen from the time of the accident and subsequently followed by M.D., at Orthopedics and Sports Medicine. The patient's primary diagnosis was that of a right ankle sprain. For this, the patient received early immobilization and subsequently underwent physical therapy.

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

The Independent Review Organization is in reference to the denial of a request for physical therapy.

The patient at the present time is now nine months post injury. Since that time, the patient has undergone extensive physical therapy under the direction of Dr.

At the present time, the patient has returned to her previous job as a and has been able to perform her job. She denies swelling at the end of the day. She denies numbness or instability. She has residual tingling in the foot. She has difficulty wearing high-heel shoes. However, at work she wears lace-up boots which do not produce any significant complaints.

There was a recent request for physical therapy. According to the records, the patient was seen in December of 2010 at Orthopedics and Sports Medicine. She had been prescribed ankle braces and orthotics.

At this time, the patient has completed physical therapy primarily for regaining strength and range of motion in the injured ankle. The patient has exceeded the treatment criteria for a soft tissue injury of the ankle. Her treatment is well outside of ODG Guidelines. There was a recent request for additional physical therapy and a subsequent denial.

From the records I have reviewed, I do not see the necessity for any continued/organized physical therapy, including passive modalities. The ODG Guidelines allow 8-12 treatments over a six-week period. The patient far exceeds that. The patient's treatment, thus far, has been appropriate. She

has been provided orthotics for protection of her ankle injury. She also has been given arch support which may be related to the injury, but most likely is the treatment of plantar fasciitis, which is unrelated to the injury.

I do not see any reason based on evidence-based medicine or within the ODG Guidelines where she would need further therapy.

If I can be of further assistance, please let me know.

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)