



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
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Notice of Independent Review Decision

**DATE OF REVIEW: 9/01/2011**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

PHYSICAL THERAPY RIGHT ANKLE/FOOT

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

M.D. Board Certified in Physical Medicine and Rehabilitation with Expertise in Pain, Wound Management and Geriatrics

**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**

Document Type	Date(s) - Month/Day/Year
Notice of Case Assignment	8/12/2011
Request for IRO	8/12/2011
Adverse Determination Notice	7/28/2011
Adverse Determination After Reconsideration Notice	8/03/2011
Radiology Report	4/14/2011



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Pre-Authorization Requests	7/14/2011-8/09/2011
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**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a female who injured her right ankle and foot on xx/xx/xxxx and complained of pain to the affected area. MRI on 4/14/2011 showed a non-displaced fracture of the right cuboid, minimal right ankle joint effusion, and grossly normal ligaments and tendons of the right ankle. She has had 12 visits of Physical Therapy with some improvement. Review of the physical therapy notes indicates she is doing some higher level strengthening and balancing. The PT note from 7/23/2011 indicates she has 3+/5 DF and 3/5 PF strength. The claimant has -2 degrees of DF, 40 degrees of PF, 24 degrees of inversion with pain and 13 degrees of eversion with pain. Gait remains antalgic. Twelve additional PT are requested.

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

This claimant has had the recommended number of visits per the Official Disability Guidelines for Physical Therapy in a diagnosis of ankle pain. The notes provided do not support the need for further supervised therapy. There is no indication that supervised therapy would be superior to a home exercise program. There is no documentation of medication management. The medical necessity of this request is unsupported by the records provided for review.

**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



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- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATUR
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES.