

# I-Resolutions Inc.

An Independent Review Organization  
8836 Colberg Dr.  
Austin, TX 78749  
Phone: (512) 782-4415  
Fax: (512) 233-5110  
Email: manager@i-resolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/27/2012

**IRO CASE #:**

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

physical therapy thrice a week for three weeks of the left ankle 97110 97124 97535 97035 (PNR G0283 99213)

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

M.D., Board Certified Orthopedic Surgery

**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**

Official Disability Guidelines

Cover sheet and working documents

Utilization review determination dated 12/29/11, 12/08/11

Letter for reconsideration dated 12/09/11

Notification of medical necessity/unresolved dispute dated 10/24/11

Office visit note dated 10/13/11, 11/16/11, 11/28/11, 10/17/11, 08/22/11, 08/29/11, 09/27/11, 12/20/11, 01/03/12, 08/30/11, 09/20/11, 10/12/11, 12/16/11, 07/27/11, 08/10/11

Handwritten note dated 10/21/11, 10/28/11, 11/04/11, 11/11/11, 11/18/11, 11/25/11, 12/02/11  
report summary dated 01/10/12

Radiographic report left ankle dated 08/22/11, 07/22/11, 08/10/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped and fell on a wet, slick floor and injured his left ankle. Radiographs revealed a non-displaced fracture of the distal fibula at the level of the talar dome. The patient was given a walking boot and crutches. The patient subsequently completed 12 sessions of physical therapy. Progress note dated 11/16/11 indicates that the patient is still having some discomfort in the ankle and some limitation in motion, but is making progress with PT. X-rays on this date show the fracture completely healed. Physical examination on 11/28/11 notes left ankle range of motion is dorsiflexion 15, plantar flexion 30, inversion 20, eversion 15 degrees. Deep tendon reflexes are normal in the bilateral lower extremities. Motor function of the left ankle is rated as 4/5. Follow up note dated 12/16/11 indicates that he has no swelling or tenderness, but still some mild limitation of inversion and eversion.

Initial request for physical therapy thrice a week for three weeks of the left ankle 97110 97124 97535 97035 (PNR G0283 99213) was non-certified on 12/08/11 noting that the patient has had 12 physical therapy visits to date. The specific, time-limited goals of treatment with objective measurable outcomes are not provided for this review to monitor the patient's progress and to delineate the probable endpoint of care for the supervised therapy. Furthermore, the number of requested visits on top of the previous therapy is deemed in excess of the recommendation of the referenced guidelines. When treatment duration exceeds the recommendation, exceptional

factors should be noted. There is none in the records submitted that mention such exceptional factors. Letter of reconsideration dated 12/09/11 indicates that they would agree to modify the initial request from 9 to 4 sessions. To avoid prescription medicine, the patient should try and regain his level of function without the use of narcotic medication and would be better served with a short course of therapy to get his ankle range of motion where it should be and then update his last home exercise program. The denial was upheld on appeal dated 12/29/11 noting that the requested number of visits already exceeds the recommendations set forth by guidelines. With a substantial number of therapy visits provided, the patient should typically have been fully progressed into an independent exercise program at this time. There is no indication that the patient's current deficits could not be addressed by a home exercise program.

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

Based on the clinical information provided, the request for physical therapy thrice a week for three weeks of the left ankle 97110 97124 97535 97035 (PNR G0283 99213) is not recommended as medically necessary, and the two previous denials are upheld. The patient sustained a non-displaced fracture of the distal fibula at the level of the talar dome and subsequently completed 12 sessions of physical therapy. Radiographs dated 11/16/11 show the fracture completely healed. Follow up note dated 12/16/11 indicates that he has no swelling or tenderness, but still some mild limitation of inversion and eversion. The Official Disability Guidelines support up to 12 visits of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The patient's compliance with a home exercise program is not documented. There are no specific, time-limited treatment goals provided. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. The reviewer finds medical necessity has not been established for physical therapy thrice a week for three weeks of the left ankle 97110 97124 97535 97035 (PNR G0283 99213).

**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)