

C-IRO Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: 10/03/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: physical therapy 2 x 4 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for physical therapy 2 x 4 weeks is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 08/23/13, 09/06/13

Letter dated 09/13/13

Handwritten physical therapy evaluation dated 08/20/13

Office visit note dated 08/13/13, 09/10/13

Electrodiagnostic study report dated 08/27/13

Handwritten note dated 03/01/13, 03/04/13, 03/07/13, 03/15/13, 03/28/13, 06/04/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date the patient accidentally hit her left leg. Note dated 08/13/13 indicates that the patient was prescribed physical therapy. The patient presents with complaints of persistent pain in the left leg with persistent numbness and tingling. On physical examination there is a well-healed scar measuring 2 x 2 cm in the left leg. There is no drainage or infection. There is residual tenderness but no swelling. Sensation is decreased in the left dorsal and lateral foot. Deep tendon reflexes are normal. Straight leg raising and Patrick's are negative bilaterally. Impression is chronic left leg pain and injury to peroneal nerve. EMG/NCV dated 08/27/13 revealed electrophysiologic finding of increased insertional activities at the left anterior tibialis muscles suggestive of probable neurapraxia of the common peroneal nerve. Follow up note dated 09/10/13 indicates that left foot great toe dorsiflexion is 4+/5. There is decreased sensation to the lateral foot and dorsal foot. There is numbness and tingling of the left foot.

Initial request for physical therapy 2 x week x 4 weeks was non-certified on 08/23/13 noting that the history and documentation do not objectively support the request for additional 8 visits of physical therapy. The claimant has attended an unknown number of PT visits for this

injury and her course of treatment and response, if any, are unknown. There is no clinical information that warrants additional extensive PT. There is no evidence that the claimant has attempted or is unable to complete her rehab with an independent home exercise program. The denial was upheld on appeal dated 09/06/13 noting that the records do not objectively support the request for an additional 8 visits of physical therapy and the records did not delineate the number of PT visits the patient has already attended for this injury, and the records did not show the results of any pat treatment. There is a lack of clinical information that can substantiate ongoing physical therapy at this time. There is no evidence that the patient had attempted or was unable to complete the rehabilitation with a home exercise program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient completed an earlier course of physical therapy after the date of injury on xx/xx/xx. It remains unclear how many sessions of physical therapy the patient has completed to date. The patient's compliance with a structured home exercise program is not documented. Given that the issues raised by the two previous reviewers have not been addressed, there is insufficient information to support a change in determination. As such, it is the opinion of the reviewer that the request for physical therapy 2 x 4 weeks is not recommended as medically necessary.

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)