

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Apr/24/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3 X a week for 4 weeks (8 weeks already approved)

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 03/12/13, 04/03/13

PT daily notes dated 02/01/13, 02/05/13, 02/12/13, 02/08/13, 02/14/13, 02/19/13, 02/21/13, 02/26/13, 02/28/13, 03/01/13, 03/05/13, 01/30/13

Office note dated 12/04/12, 12/19/12, 12/26/12, 01/09/13, 01/23/13, 02/06/13, 02/20/13, 03/13/13, 04/03/13

MRI right ankle dated 11/19/12

Procedure note dated 12/13/12

Medical record review dated 04/02/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient rolled her right ankle while carrying. MRI of the right ankle dated 11/19/12 revealed osteochondral lesion of the medial talar dome measuring 10 mm AP x 5 mm transverse x 3 mm with full thickness chondral erosions and edema; subacute sprain or neoligament formation of the anterior talofibular ligament. The patient underwent allograft, tibial osteotomy and posterior splint application on 12/13/12. Progress note dated 12/19/12 indicates that neurologic exam is normal to light touch. Tinel's is negative bilaterally. Deep tendon reflexes are normal bilaterally. The patient completed 12 postoperative physical therapy visits. Follow up note dated 04/03/13 indicates that pain level is 7/10. Medications are listed as Meloxicam, Zofran, Miralax, Tramadol, Zipsor and Lyrica.

Initial request for physical therapy 3 x week x 4 weeks was non-certified on 03/12/13 noting that there are no physician records to support the requested therapy. There is not documentation of functional deficits. The claimant's current examination findings and functional limitations are unknown. While a short course of therapy might be of benefit, the requested therapy is not recommended based on the limited information provided. The denial was upheld on appeal dated 04/03/13 noting that based on the extent of injury and the amount of physical therapy which has already been rendered, more definitive treatment is needed, and physical therapy is not further indicated at this time.

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

The patient underwent surgical intervention on 12/13/12 and has completed 12 postoperative physical therapy visits to date. The patient's objective functional response to therapy is not documented to establish efficacy of treatment and support ongoing therapy. The Official Disability Guidelines support ongoing physical therapy only with evidence of objective functional improvement. As such, it is the opinion of the reviewer that the request for physical therapy 3 x a week for 4 weeks (8 weeks already approved) 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)