

## IRO REVIEWER REPORT TEMPLATE -WC

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Notice of Independent Review Decision

**Date notice sent to all parties: 9/13/2013**

**IRO CASE #:**

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

12 sessions of physical therapy to the right tibial plateau fracture

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

Texas Licensed, Board Certified Orthopedic Surgeon

**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 of the health care services in dispute.

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. Notice of IRO Assignment
2. LHL009
3. 7/3/13 and 7/26/13 denial letters
4. 9/12/13 Prospective Review (M2) Response
5. 6/23/13 notes
6. 6/18/13, 5/31/13, 4/8/13, 7/31/13 prescriptions
7. 6/27/13, 5/24/13 OT Therapy PT Update
8. 2 page print out
9. 7/23/13 fax and handwritten response
10. 7/23/13 Appeal Reconsideration Acknowledgement Letter
11. 4/11/13, 7/23/13, and 5/29/13 28 TAC 134.600 for Pre-authorization
12. 1/18/13 Medical Center Operative Note
13. OP Therapy Service (PT) Initial Plan of Care
14. Request for Utilization Review
15. 2/18/13 Evaluation
16. 2/11/13 Operative Note and Discharge Summary
17. Skeletal Trauma patient notes through 3/27/13
18. 3/8/13, 6/18/13, 8/26/13, Texas Workers Compensation Status Reports
19. Central Texas Patient Progress Notes from beginning of stay to 7/8/2013
20. 6/20/13 Rendon Progress Report
21. 7/2/13 Email

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was documented to have sustained a comminuted tibial plateau fracture along with a fibula fracture. On the date of injury of xx/xx/xx, the claimant was working. His foot reportedly slipped. He underwent treatment including external fixation and then open reduction and internal fixation. He also underwent a fasciotomy for impending/compartament syndrome. This occurred on 01/18/2013. The claimant was noted to have completed a series of home health treatments and 30 outpatient physical therapy treatments. The claimant has been most recently considered for additional therapy by the treating provider; however, this has reportedly been denied based on the lack of medical necessity. The treating provider has requested an appeal and has had therapy records submitted from Central including progress notes from the spring and summer of 2013. The letter from the physical therapist indicating the medical necessity for ongoing therapy to allow for return to independent lifestyle overall was noted albeit apparently dated or received 07/09/2013. The prior denial letters were reviewed revealing a lack of recent subjective and/or objective abnormalities in the claimant's overall condition. The denial letters also indicated that the claimant would likely have already been prescribed and reasonably well versed in a self-administered therapy protocol. The additional denials also reveal that the claimant was able to walk up 3 flights of stairs in addition.

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

In this reviewer's opinion, the claimant's recent deficits and/or objective findings have not been documented. In addition, the most recent available documentation evidences quite reasonable functionality and overall motion of the affected extremity joints along with strength. Therefore at this time, the applicable clinical guidelines do not support ongoing formal supervised physical therapy as opposed to exclusively a prescribed and self-administered protocol. The claimant, who was noted to have had apparent uneventful healing process, does appear to be at a point in which he would be able to exclusively have a medical necessity for a prescribed and independent self-administered protocol based on the objective findings most recently available for review. Guidelines: ODG, lower extremity fractures, physical therapy, tibia and fibula.

**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):**