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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/20/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: physical therapy 3 x 4 right foot

A 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)

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 3 x 4 right foot

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped. MRI of the right foot dated 12/26/13 revealed moderately advanced cartilage loss and joint space narrowing involving the first metatarsal phalangeal joint. There are small areas of cystic change and bony overgrowth. There is moderate to moderately advanced and joint space narrowing involving the third and fourth metatarsal tarsal joints. There are small areas of subchondral edema and mild bony overgrowth as well as small areas of cortical irregularity. Note dated 12/31/13 indicates that injections have been helping. Note dated 07/17/14 indicates that the patient complains of neuroma pain right foot. Medications are listed as Tylenol-Codeine, Relafen, methylprednisolone and Femara. On physical examination skin temperature is warm bilaterally. There is no tenderness to palpation of the 2nd, 3d and 4th metatarsal. There is tenderness to palpation of the second and third intermetatarsal space. Morton's test is positive for the second and third intermetatarsal space. Assessment notes tendonitis, neuralgia and intermetatarsal neuroma.

Initial request for physical therapy 3 x 4 was non-certified on 05/06/14 noting that the patient has had 9 physical therapy visits. The claimant reports 70% improvement and was discharged from physical therapy on 04/21/14 with a home exercise program to address range of motion and strength. Ongoing deficits which require a return to skilled care are not outlined. There is no indication that the claimant has experienced a recent flare-up of pain after a specific incident of aggravation with an associated significant decline in function which has been unresponsive to the prescribed home exercise program. The denial was upheld on appeal dated 07/23/14 noting that objective evidence of functional gains with prior therapy would be necessary to support ongoing therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injury to the right foot in xx/xxxx and has completed 9 physical therapy visits to date. The Official Disability Guidelines support up to 10 sessions 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 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. As such, it is the opinion of the reviewer that the request for physical therapy 3 x 4 right foot 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)