

# US Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Oct/15/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** PT RT FOOT 3X'S WK 6 WKS

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., 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 PT RT FOOT 3X'S WK 6 WKS is not recommended as medically necessary.

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is described as a motor vehicle accident. Progress note dated 07/11/14 indicates that the patient is status post ORIF right calcaneus on 05/23/13. On physical examination she has excellent subtalar motion. Coleman's block test finds that her pain is decreased and her hindfoot alignment improves. X-rays demonstrate a healed calcaneus fracture. Current medications are listed as Lisinopril, Vytorin, Zolpidem, Aspirin, and Effexor.

Initial request for physical therapy right foot 3 times a week x 6 weeks was non-certified on 07/17/14 noting that the claimant has participated in previous physical therapy; however, no physical therapy progress notes were submitted for review. There is no significant functional deficit to support ongoing physical therapy as opposed to a self-directed home exercise program. The denial was upheld on appeal dated 08/18/14 noting that submitted report does not outline evidence of objective and functional gains from the completed visits to warrant additional visits. There is no clear evidence as to how many sessions of physical therapy have been completed at this time.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on xx/xx/xx. The patient reportedly underwent ORIF right calcaneus on 05/23/13. The operative report is not submitted for review. There is no comprehensive assessment of postoperative treatment completed to date or the patient's response thereto submitted for review. The number of physical therapy visits completed to date and the patient's objective functional response to prior physical therapy is not documented to establish efficacy of treatment and support additional physical therapy visits in accordance with the Official Disability Guidelines. There are no specific, time-limited treatment goals provided. As such, it is the opinion of the reviewer that the request for PT RT FOOT 3X'S WK 6 WKS 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)