

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/05/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 9 additional sessions of physical therapy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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 9 additional sessions of physical therapy is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped on the stairs and sustained a right ankle fracture. She underwent ORIF on 07/11/14. Handwritten note dated 11/06/14 indicates that therapy is helping; the pain does come and go. Walking long distance is painful. Current medications are Tramadol, Avapro, Lyrica and Zanaflex. Gait is slowed and the patient is limping to the right. Progress note dated 11/10/14 indicates that the patient has completed 30 physical therapy visits to date. The patient reports she has tightness and pain in both her ankle and her fibula. Pain is rated as 4/10 with current activity. Diagnosis is fracture lateral malleolus closed. Note dated 11/14/14 indicates the patient has completed 33 physical therapy visits. Pain is 3-4/10.

The initial request for 9 additional sessions of physical therapy was non-certified on 11/17/14 noting that therapy for trimaleollar fracture surgical repair is 21 visits over 16 weeks. Records indicate the claimant has completed 33 postoperative PT sessions and that home program instructions have been outlined. There are no extenuating circumstances noted to exceed current treatment guidelines or that this claimant cannot perform a home exercise program. Appeal letter indicates that the patient walks with a guarded affected limb. She has made slow progress toward all long-term goals. She continues to have very weak ankle musculature and continued DF stiffness has put her at a high fall risk. She is unable to complete a calf raise without assistance. The denial was upheld on appeal dated 12/11/14 noting that the Official Disability Guidelines recommend up to 21 visits over 16 weeks for this type of injury. The patient was noted to be doing well with little to no residual pain except arthritic type pain when she uses her legs too much. The documentation provided evidence that 33 visits of physical therapy had been provided to the patient. The request exceeds Official Disability Guidelines recommendations for total duration of care. The guideline

recommendations do not support extended treatment without documentation of exceptional factors. There are no exceptional factors noted within the submitted documentation.

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

The patient underwent ORIF right ankle fracture and has completed 33 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 21 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 9 additional sessions of physical therapy is not recommended as medically necessary and the prior denials are upheld.

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)