



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

DATE OF REVIEW: 3/23/2016

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy 2-3x per week x 4 weeks; 12 sessions.

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

M.D. Board Certified in Occupational Medicine and Urgent Care.

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)

PATIENT CLINICAL HISTORY [SUMMARY]

The claimant is an XX beneficiary who has filed a claim for chronic foot, ankle, and heel pain reportedly associated with an industrial injury of XX/XX/XX. In a utilization review report dated XX/XX/XX, the claims administrator denied a request for 12 sessions of physical therapy for the ankle. A XX/XX/XX physical therapy progress note was referenced in the determination. The attending provider and/or the claimant subsequently appealed. On a subsequent utilization review report dated XX/XX/XX, the claims administrator upheld the previous denial. The claimant apparently appealed further. On a medical progress note dated XX/XX/XX work restrictions were renewed. The claimant had sustained a strain of the Achilles tendon and was using a Controlled Ankle Movement (CAM) walker, it was suggested. Additional physical therapy was sought at this point. On XX/XX/XX, the treating therapist noted that the claimant exhibited a visibly antalgic gait. Persistent complaints of plantar foot and heel pain were reported, 3-5/10. Diminished range of motion and strength were apparently appreciated in certain planes and muscle groups, secondary to pain. Additional treatment was sought.

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

Per ODG references, the requested "Physical therapy 2-3 x week x 4 weeks/ 12 sessions" is not medically necessary. The claimant had prior treatment (at least 9 sessions, per a prior UR report dated XX/XX/XX), seemingly in-line with the 9 to 10 sessions suggested in ODG's Chronic Pain Chapter Physical Medicine Treatment Topic for myalgias and myositis of various body parts, i.e., the diagnosis reportedly present here. This recommendation is further qualified by commentary made in ODG's Chronic Pain Chapter Functional Improvement Measures Topic to the effect that functional improvement measures should be invoked repeatedly over the course of treatment so as to demonstrate progress in terms of return to functionality and/or maintenance of function which would otherwise deteriorate. A physical therapy progress note dated XX/XX/XX, was notable for commentary that the claimant exhibited an antalgic gait, pain-limited range of motion, and pain-limited strength about the injured ankle. Work restrictions were renewed on a medical progress note dated XX/XX/XX.



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The claimant was still using a CAM walker as of that date. All of the foregoing, taken together, argued against the claimant's having improved appreciably in terms of the functional measures established in ODG with prior treatment. It did not appear likely that the claimant could stand to gain from further treatment, going forward. There were no extenuating circumstances that would indicate the necessity of additional therapy. It is further noted that the request for authorization was seemingly initiated by the treating therapist XX/XX/XX, without an intervening office visit with the attending provider so as to assess program progression, functional improvement, and/or clear goals for further treatment, going forward. Therefore, the request is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- 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