IMedReviews
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DATE OF REVIEW: 6/25/2018

IRO CASE # XXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
"Physical therapy X 12 sessions for the left foot/ankle" for the patient.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D. Board Certified in Physical Medicine and Rehabilitation.

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]:

This is a request for 12 visits of physical therapy for the left foot/ankle. The treating diagnoses include a left ankle sprain, left Achilles tendonitis, and a cavovarus deformity of the foot. The request was made by XX (orthopedic surgery) on XX.

A physical therapy initial evaluation on XX notes that the patient is a XX who presented signs of consistent ankle instability in physical therapy. The patient was noted to be status post a calcaneal fibular ligament repair. The patient also had limitations in running, lifting, exercising and golfing. XX was noted to have a job requiring a medium physical demand level. Therefore, a physical therapy program was recommended in this regard.

A prior physical therapy referral of XX by XX recommended 12 visits of physical therapy. On XX an office note from XX noted the patient was doing reasonably well, but felt XX ankle was weak. The patient was trying to get additional physical therapy approved. On exam, the patient had a well healed incision with tenderness over the lateral talar dome and slight tenderness at the distal Achilles tendon. A Thompson test was normal. Additional physical therapy was recommended. XX felt the patient was able to work but XX had

restrictions in climbing. XX anticipated return to full duty in the near future.

On XX a physician reviewer reviewed the patient's history of extensive physical therapy over the course of this injury, which began on XX. This reviewer noted that the Official Disability Guidelines recommended nine sessions for this injury, and in XX alone, the patient had received 12 sessions, in addition to other treatment.
On XX, a physician review recommended noncertification of additional physical therapy visits.

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

Per ODG references, the requested "Physical therapy X 12 sessions for the left foot/ ankle for the patient" is not medically necessary. For an ankle/foot strain with a history of postsurgical treatment, the guidelines recommend "34 visits over 16 weeks."
More important than a specific number of visits, the guidelines generally recommend instruction in an individualized rehabilitation program with a subsequent transition to independent active home rehabilitation.

The records provided do not clearly document a rationale or goals explaining why the patient would require additional supervised rehabilitation, rather than continuation of a home rehabilitation program. Similar concerns noted in a prior physician review have also not been addressed in the materials provided. For these reasons, this request is not medically necessary and should be noncertified.

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 KNOWLEDGE BASE
- ☐ 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

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- ☐ 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