

CORE 400 LLC

240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 1, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional 12 Sessions of Physical Therapy

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

MD, Board Certified Orthopedic Surgeon

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 or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Additional 12 Sessions of Physical Therapy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI right knee. 02/12/08
Office note, Dr. , 03/24/08
Operative report, 05/08/08
Prescription, 07/02/08
Office note, Dr. , 08/13/08
FCE, 08/27/08
Initial interview, Dr. , 08/27/08
Office note, Dr. , 09/05/08

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Knee and Leg:
Physical medicine treatment
Adverse Determination Letters, 8/19/08, 8/27/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year-old female injured her right knee on xx/xx/xx after a slip and fall. An MRI of the right knee performed on 02/12/08 showed a prior anterior cruciate ligament repair, medial and lateral menisci tears and superimposed degenerative change. Pain and swelling of the right knee continued despite physical therapy. The claimant subsequently underwent a right knee partial medial and lateral meniscectomy, loose body removal and chondroplasty of a chondral injury patella and medial and lateral compartment.

A 08/13/08 physician record noted that the claimant had completed ten sessions of the rehabilitation program with continued right knee pain. There was some improvement in strength and walking tolerance and improved range of motion. An examination revealed medial joint line pain, and patellar grind was positive for significant pain along the right knee joint. The claimant was diagnosed with internal derangement of the knee and a medial meniscus tear. Continuation of the rehabilitation program was recommended.

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

An additional 12 sessions of physical therapy is not medically indicated and appropriate in this xx year-old female who is status post surgical arthroscopy of her right knee with partial lateral medial meniscectomy with removal of loose bodies, chondroplasty of the patella in medial and lateral compartments on 05/08/08. She postoperatively has already had 20 sessions thus far based upon an office visit on 09/05/08 by Dr. . A functional capacity evaluation on 08/27/08 demonstrates an ability to safely and independently perform at a light physical demand level. Notably, an adjustment disorder was noted. These medical records do not support need for further physical therapy. The reviewer finds that medical necessity does not exist for Additional 12 Sessions of Physical Therapy.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Knee and Leg:
Physical medicine treatment

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 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)