

Core 400 LLC

An Independent Review Organization
7000 N Mopac Expressway, Suite 200
Austin, TX 78731
Phone: (512) 772-2865
Fax: (530) 687-8368
Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/28/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional PO PT for left knee

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

M.D., 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. The reviewer finds medical necessity is not established for Additional PO PT for left knee.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review adverse determination 09/20/12

Utilization review adverse determination 10/05/12

Reconsideration request 10/02/12

Therapy referral 09/27/12, 09/06/12

Office visit notes 08/09/12 – 09/27/12

Physical therapy reevaluation 09/17/12

Pre-authorization request 09/17/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is XXXX. The records indicate that he was stepping out when his left knee buckled and twisted. The claimant is status post left knee arthroscopy on 08/07/12 with meniscectomy, lateral release, and plica resection. Records indicate that the claimant completed 12 postoperative physical therapy visits. The claimant was recommended to undergo additional physical therapy to the left knee 2-3 times a week for 4 weeks per physical therapy reevaluation dated 09/17/12.

A request for additional postoperative physical therapy for the left knee x12 was denied per utilization review dated 09/20/12. The reviewer noted that the claimant was initially evaluated for physical therapy on 08/13/12 and has attended 12 visits to date. He was seen for reevaluation on 09/17/12. His pain was described as constant throbbing in the anterior left knee with some mild stiffness persisting. There was mild swelling, usually at the end of the day or with activities. There was no reported buckling. The claimant had some difficulty with sit-to-stand and bending the knee. He reported good compliance with a home exercise program as if the physical therapy treatments are improving function and benefitting.

Examination revealed apparent pain and tenderness throughout the infrapatellar region and portal sites mostly. Active range of motion of the left knee reported extension (supine) 0; knee flexion (supine) 72; knee flexion (seated) 90. The active range of motion measurements of the left knee on 08/13/12 were the same. Isometric test of strength noted 4/5 in the left lower extremity. There was no extensor lag when performing straight leg raising (previously 10 degrees). It was noted that ODG states up to 12 postoperative physical therapy visits are recommended following arthroscopic meniscectomy. However, medical records do not clearly establish objective and measured functional gains, improvement with activities of daily living, or discussion regarding return to work as a result of previous physical therapy. Additionally, the proposed number of visits in addition to the number of visits already completed would exceed guideline recommendations. There was no clear description of education with respect to independent exercises, compliance, or failure of an independent program to address residual deficits. Non-certification was recommended.

An appeal request for additional postoperative physical therapy for the left knee 3x4 was denied per utilization review dated 10/05/12. It was noted that the claimant was reported to have done well with physical therapy; however, Official Disability Guidelines recommend 12 postoperative therapy visits. The requested number of visits in addition to the number of visits already completed would exceed guideline recommendations. There was no clear description of education with respect to independent exercises, compliance, or failure of an independent program to address the residual deficits. It is unclear why the claimant is unable to transition to a home-based exercise program instead of continuing physical therapy sessions. Therefore, the request is not medically necessary.

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

The claimant is status post left knee arthroscopy with meniscectomy, lateral release, and plica resection performed on 08/07/12. Initial physical therapy evaluation was performed on 08/13/12 and the claimant completed 12 physical therapy visits. Physical therapy reevaluation on 09/17/12 reported that active range of motion measurements were noted to be unchanged from previous measurements taken on 08/13/12. Records indicate that the claimant reports good compliance with a home exercise program. The claimant has completed the number of postoperative physical therapy visits (12) that is recommended by Official Disability Guidelines. There is no documentation of exceptional factors that would support the need for therapy that exceeds guideline recommendations either in duration or in number of visits. The claimant is currently performing a home exercise program, and there is no indication that residual deficits cannot be addressed with a home exercise program. Accordingly, the reviewer finds medical necessity is not established for Additional PO PT for left knee.

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)