

I-Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd Ste 117-501
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/08/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 Additional Post op PT

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

M.D., 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 medical necessity exists for each health care service in dispute. The reviewer finds medical necessity is not indicated for the requested 12 Additional Post op PT.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Office visit notes dated 04/26/12-10/18/12

Operative report 05/16/12

PT evaluation summaries 06/03/12-06/06/12 and 06/04/12-06/27/12

Therapy orders 09/06/12

Rehabilitation progress report 09/10/12

Utilization review determination dated 09/19/12

Utilization review determination dated 10/08/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped on a step and reported pain in the anterior aspect of his knee. MRI showed a distal quadriceps tendon tear. The patient underwent left knee quadriceps tendon repair on 05/16/12. The patient subsequently completed 36 postoperative physical therapy visits. Follow up note dated 09/06/12 indicates that he reports no pain. On physical examination there is atrophy present at the quadriceps. He has approximately 10 degrees extensor lag. He is able to do a straight leg raise. Range of motion is from 0-120 degrees. There is no defect present at the quadriceps and no joint effusion. Homans and Moses testes are negative.

Initial request for 12 additional postoperative physical therapy visits was non-certified on 09/19/12 noting that there is no report of residual weakness that would be expected to respond better to additional strengthening exercises supervised by a therapist than to additional strengthening exercises performed independently by him, and no report by the treating physician of exceptional circumstances that would necessitate further supervision of exercises by a therapist. The denial was upheld on 10/08/12 noting that current clinical

guidelines recommend continuation of supervised physical therapy if prior sessions have demonstrated therapeutic effectiveness, and the residual functional deficits could not be managed by a program of self-directed exercise. The goal of additional knee strengthening could result from a program of self-directed exercise.

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

The patient underwent quadriceps tendon repair on 05/16/12 and subsequently completed 36 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 34 visits 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 per the guidelines. As such, the reviewer finds medical necessity is not indicated for the requested 12 Additional Post op PT.

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)