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Notice of Independent Review Decision

September 21, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy three times per week for four weeks (additional 12 sessions) to the left knee

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

Board Certified Physical Medicine and Rehabilitation and Pain Management

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI

- Utilization reviews (08/17/12 – 08/24/12)
- Therapy (05/07/12 - 08/06/12)
- Utilization reviews (08/17/12 – 08/24/12)
- Medical evaluation (08/21/12)

- Diagnostic study (02/27/12)
- Office visits (03/30/12 – 08/23/12)
- Operative note (04/02/12)
- Therapy (05/07/12 – 08/10/12)
- FCE (09/04/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who had a work-related injury on xx/xx/xx. The patient reports he was working on a ramp in the rain and he fell down, landing wrong and causing a tendon rupture to his left knee.

On February 27, 2012, the patient underwent a magnetic resonance imaging (MRI) of the left knee. The findings included: (1) Patella tendon disruption with superior riding patella. (2) Mild sprain of the medial collateral ligament (MCL). (3) Mild mucoid degeneration in the lateral meniscus and mild degenerative spurring of the lateral compartment.

On March 20, 2012, D.O., evaluated the patient for his left knee injury. It was noted the patient had no surgical treatment and he was frustrated with the delay in his treatment. On examination, deep tendon reflexes (DTRs) were within normal limits except for the left patellar tendon. The patient could not extend his left knee secondary to his injury. There was an effusion to the left knee. Varus and valgus stress testing at 0 and 30 degrees of flexion were negative for instability. There was decreased flexion of the left knee. There was no extension of the left knee secondary to acute patellar tendon rupture. There was joint line tenderness. MRI of the left knee was reviewed and interpreted as showing an acute complete tear of the patellar tendon. Dr. recommended urgent approval for repair of the patellar tendon rupture.

On April 2, 2012, Dr. performed open repair of acute ruptured tendon of the left patella.

On April 12, 2012, Dr. noted that the wounds were excellent with no sensory or motor deficits. The staples were removed and the patient was instructed to continue the brace locked in full extension. He was not to bend the knee and was told to return in three weeks for re-evaluation.

On May 3, 2012, Dr. noted that the wounds were excellent. He adjusted the brace allowing 0 to 40 degrees of flexion. Dr. recommended physical therapy (PT) three times a week for four weeks. The patient was continued off work.

On May 7, 2012, the patient underwent an initial evaluation at Physical Therapy. He complained of pain in the left knee area rated as 6/10. He had decreased ability with activities of daily living (ADLs). He was also unable to return to work (RTW).

From May 7, 2012, through June 1, 2012, the patient underwent ten sessions of PT consisting of electrical stimulation, manual therapy, group exercise and therapeutic activities.

On May 17, 2012, Dr. noted that the patient was doing well with PT. He was still wearing the brace. Dr. recommended continuing PT and gradually to discontinue the brace and increase his flexion as tolerated.

From June 4, 2012, through August 10, 2012, the patient attended 37 sessions of PT. Modalities consisted of electrical stimulation, group exercise, manual therapy and therapeutic activities.

On June 20, 2012, the patient reported that he was progressing well with therapy. He still had significant weakness with extension of his left knee. Range of motion (ROM) was increasing but his weakness persisted in the quadriceps muscle. There was active extension of the left knee, but severe weakness with extension of the left knee against gravity. The patient was placed off-work and given prescription to continue therapy.

On July 9, 2012, Dr. gave a prescription for anterior cruciate ligament (ACL) derotation brace.

Per utilization review dated August 17, 2012, the request for PT three times per week for four weeks to the left knee was non-authorized. Rationale: *“The history and documentation, and the Official Disability Guidelines (ODG) do not objectively support the request for additional PT at this time. The claimant has attended postop PT and there is no evidence that he remains unable to continue and complete his rehab with an independent home exercise program (HEP). There is no indication that continuation of supervised exercises is likely to provide him with significant or sustained benefit that he cannot achieve on his own. The medical necessity of this request has not been clearly demonstrated and a clarification was not obtained. Peer-to-peer contact was not successful.”*

On August 21, 2012, M.D., performed a maximum medical improvement/impairment rating (MMI/IR) evaluation. He diagnosed left knee patellar tendon disruption and left knee medial collateral sprain/strain. He assessed MMI as of August 2, 2012, with 4% whole person impairment (WPI) rating. Dr. opined that the patient would only be suitable for sedentary duty. The patient was limited to four hours of walking, four hours of standing, two hours of kneeling or squatting and no carrying over 35 pounds for more than four hours per day.

Per reconsideration review dated August 24, 2012, the appeal for 12 additional sessions of PT to the left knee was non-authorized. Rationale: *“Based on the clinical information provided, the appeal request for additional 12 PT sessions is not recommended as medically necessary. There is insufficient clinical*

information provided to support this request. The patient underwent open repair of his left patellar tendon on April 2, 2012, and has undergone a course of postoperative PT; however, the number of sessions completed to date is not documented. Without additional information, the request is not indicated as medically necessary."

On September 4, 2012, the patient underwent a functional capacity evaluation (FCE). According to the evaluator, the patient did not qualify for his job description. The result indicated that the patient was able to work at the light-medium physical demand level (PDL) versus the medium PDL required by his job of a xx. The evaluator opined that the patient would benefit from a work conditioning program (WCP) four hours per day, five times a week for four to six weeks to improve strength and stability of the left knee during functional and work related activities.

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

ODG allows physical therapy for a Patellar tendon rupture (ICD9 727.66) and post-surgical treatment: 34 visits over 16 weeks. (The previous reviews have used patella fracture as the diagnosis.)The patient has completed the post-surgical PT and is not a candidate for further post-surgical PT. However, according to the ODG, the patient is a candidate for Work Conditioning (WC) that allows for 10 visits over 4 weeks, equivalent to up to 30 hours. WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision. The patient has met the criteria for admission to WC program according to the ODG. The following criteria has been met: prescription, screening documentation, job demands, FCE (functional capacity evaluation), previous PT, rule out surgery, healing, return to work plan and supervision by PT.

At the time of discharge, the referral source and other predetermined entities should be notified of discharge documentation. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence. Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

IRO REVIEWER REPORT TEMPLATE -WC

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES