

Core 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

five sessions of left knee physical therapy

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

M.D., Board Certified Orthopedic Surgeon (Joint)

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. It is the opinion of the reviewer that medical necessity does not exist for the requested five sessions of left knee physical therapy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 08/13/12, 09/05/12, 04/23/12, 04/05/12, 03/14/12

Prospective review response dated 09/08/12

Discharge summary dated 05/18/12

Exercise flow sheet dated 03/19/12-04/14/12, 06/08/11-06/23

Handwritten initial evaluation dated 06/08/11

Initial evaluation dated 03/19/12

Progress report dated 03/30/12, 04/16/12, 03/19/12

Daily note charge sheet dated 04/14/12, 04/13/12, 04/09/12, 04/07/12, 03/30/12, 03/28/12, 03/26/12, 03/24/12, 03/23/12, 03/21/12, 03/19/12, 06/08/11, 06/14/11, 06/15/11, 06/16/11, 06/17/11, 06/20/11, 06/22/11, 06/23/11

Request for reconsideration dated 08/22/11

Notice of preauthorization dated 06/14/11

Communications log dated 03/20/12-04/18/12

Designated doctor evaluation dated 10/10/11

Encounter summary dated 05/16/12, 07/18/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. She was walking in the hallway

when she bumped into dragging his backpack and she fell on her left knee and hand. She had left knee arthroscopic partial medial and lateral meniscectomy on 06/07/11 and was authorized for 12 postoperative physical therapy visits to date. Initial evaluation dated 03/19/12 indicates that the patient attended physical therapy and felt "80% back to normal" upon discharge. She began to experience increased pain a couple months later and has been getting worse ever since. Encounter summary dated 07/18/12 indicates that the patient continues to have pain on the lateral aspect and proximal medial tibial pain some days. On physical examination there is no mass, induration, warmth, erythema, swelling or knee deformity. Complete extension and flexion to 130 degrees with anterior tightness. The report documents a stable knee exam and intact neurovascular status. The request for additional PT was denied. The reviewer notes that a medical record of 07/18/12 documented ongoing complaint of pain but patient has good range of motion and there were no significant clinical findings. In the documentation received there is no basis for further formal therapy over a home exercise program.

No unusual findings were documented that would necessitate exceeding the guideline recommendations. The request was denied a second time as no additional documentation was provided for review. Guidelines would support twelve postoperative physical therapy sessions over twelve weeks. Without further documentation of deficits on physical examination such as decreased range of motion, effusion, muscular atrophy or significant complaints that have failed lower levels of care, formal physical therapy in excess of guideline recommendations would not be supported. The claimant has undergone 11 of 12 certified physical therapy sessions to date without documentation of significant deficits. Records do not reflect the clinical necessity of ongoing formal therapy versus an aggressive home exercise program.

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

This patient had left knee arthroscopic partial medial and lateral meniscectomy on 06/07/11 and has been authorized for 12 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 12 visits 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's physical examination is grossly unremarkable. It is the opinion of the reviewer that medical necessity does not exist for the requested five sessions of left knee physical therapy.

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)