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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/10/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: six sessions of physical therapy to the right foot

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Family Medicine

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 the request for six sessions of physical therapy to the right foot is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date the patient twisted the right ankle while walking on an uneven surface. Follow up note dated 09/02/14 indicates that pain is rated as 3/10. There is slight swelling. Overall the symptoms have remained the same. Follow up note dated 09/30/14 indicates that pain is 7-8/10. Range of motion is ok but still not full. There is slight swelling. Range of motion has remained the same. Numbness and tingling has resolved. Strength has remained the same. Current medication is naproxen. The patient has completed 13 physical therapy visits to date.

Initial request for six sessions of physical therapy to the right foot was non-certified on 09/09/14 noting that the patient has completed 12 visits of physical therapy to date. It is not clear what the long term plan of care involves at this time. She does not appear to have been reevaluated by the orthopedist and no long term plan is outlined. Injured worker's current work status is not known. Injured worker should be reevaluated by the orthopedist and a plan of care should be outlined prior to approval or consideration of the additional physical therapy request. Appeal letter dated 09/15/14 noted that x-ray was negative for fracture, but MRI on 07/14/14 showed that she has a minimally displaced distal half of calcaneus fracture. Her current condition is not improving. The denial was upheld on appeal dated 10/09/14 noting that the physical therapy re-evaluation reported that the claimant would be independent in a home exercise program after the additional visits. The records do not reflect why after the previous 13 physical therapy sessions the claimant would not be well versed in a home exercise program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained a minimally displaced calcaneus fracture and has completed 13 physical therapy visits to date. The Official Disability Guidelines support up to 12 sessions 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 such, it is the opinion of the reviewer that the request for six sessions of physical therapy to the right foot is not recommended as medically necessary. The prior denials are upheld.

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)