

True Decisions Inc.

An Independent Review Organization
512 W. MLK Blvd., PMB 315
Austin, TX 78705
Phone: (512) 879-6332
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

April/1/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Continuation of PT 3 X week X 8 wks (24 sessions already approved)

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who has previously undergone an ACL repair. The therapy note dated 02/05/14 indicates the patient undergoing rehabilitation following the ACL repair. The note indicates the patient having undergone a surgery on 11/21/13. The note indicates the patient showing strength deficits measuring 49%.

The utilization review dated 02/25/14 resulted in a denial for additional physical therapy as the therapy request included modality G0283 which is a passive modality and not supported for treatment of this injury. Additionally, further physical therapy was not medically necessary without a recent updated reevaluation by the treating physician.

The utilization review dated 03/11/14 resulted in a denial as there was no indication that the patient had undergone a reevaluation by the treating physician.

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

The documentation indicates the patient having undergone an ACL repair in November of

2013. The therapy notes indicate the patient having completed 26 physical therapy sessions to date as part of the postoperative treatment. 24 physical therapy sessions are recommended following an operative procedure of this nature. However, the request involves G0283 which is not supported as a modality for this treatment. Additionally, no updated evaluation was included in the documentation confirming the ongoing need for additional physical therapy. Given these factors, the request is not indicated. As such, it is the opinion of this reviewer that the request for a continuation of physical therapy 3 x a week x 8 weeks is not recommended as medically necessary.

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)