

Core 400 LLC

An Independent Review Organization
3801 N Capital of TX Hwy Ste E-240 PMB 139
Austin, TX 78746-1482
Phone: (512) 772-2865
Fax: (530) 687-8368
Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/05/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 12 sessions of physical therapy

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

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 12 sessions of physical therapy is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. He was walking when his right knee gave out with no obvious cause. His flexed right knee struck the concrete surface. Treatment to date includes right knee arthroscopy with ACL reconstruction on 01/31/13, right knee arthroscopy with attempted re-repair of medial meniscus and partial medial meniscectomy on 07/16/13, right knee arthroscopy with revision ACL graft reconstruction with tibialis posterior tendon allograft, partial medial and partial lateral meniscectomy on 01/16/14. Note dated 02/26/14 indicates that he has attended physical therapy 3 times a week and home exercise program every day. Follow up note dated 04/14/14 indicates that approximately two weeks ago the patient noticed a stabbing pain with extension of his knee at rest with weightbearing. He went to physical therapy who did exercises, but they did not help. On physical examination anterior drawer, posterior drawer and anterior Lachman are negative. Re-evaluation dated 05/23/14 indicates that the patient has completed 47 physical therapy visits. Right knee range of motion is 02 to 135 degrees. Office visit note dated 06/25/14 indicates that he has been doing his home exercise program twice daily.

Initial request for 12 sessions of physical therapy was non-certified on 06/13/14 noting that he has completed twenty-seven postoperative physical therapy visits. He underwent surgical procedure on 01/16/14. When recently seen on 05/12/14, there was no pain with flexion/extension. Range of motion was -2 to 135. He did have residual weakness. He can advance to a home exercise therapy program. The denial was upheld on appeal dated 07/09/14 noting that he has completed 27 visits in therapy following the most recent surgery and physical therapy notes document little in the way of progress. Official Disability Guidelines permit up to 24 visits over sixteen weeks in therapy status post anterior cruciate ligament repair. This claimant has exceeded the amount of therapy recommended by guidelines and has failed to progress in therapy; additional therapy would not be expected to be of great benefit.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent right knee arthroscopy with revision ACL graft reconstruction with tibialis posterior tendon allograft, partial medial and partial lateral meniscectomy on 01/16/14 and has completed 27 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 24 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 12 sessions of physical therapy 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)