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An Independent Review Organization

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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Physical Medicine And Rehab

Description of the service or services in dispute:

Physical Therapy 3 X 4, 12 visits

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)

Patient Clinical History (Summary)

The patient is a male whose date of injury is xx/xx/xx. The patient fell off of a x and twisted his left knee. MRI of the left knee dated 12/30/14 revealed extremely attenuated proximal ACL, very suspicious for tear; markedly thickened, possibly calcified, MCL; medial meniscal tear near the junction of the anterior horn and body. The patient underwent left knee ACL reconstruction and partial excision medial meniscus tear on 02/12/15. Knee evaluation dated 03/02/15 indicates that knee range of motion is 8-97 degrees. Strength is 3+/5 knee flexion and 2-/5 knee extension. Progress note dated 06/04/15 indicates that the patient has completed 38 physical therapy visits. He is not yet able to tolerate kneeling, but he is able to squat. Left knee range of motion is 0-140 degrees. Strength is 4-/5. Follow up note dated 06/15/15 indicates that x is not pleased at all with his progress. He states the knee is still very unstable and he has been having some swelling. He feels that in spite of cycling for up to 45 minutes to an hour a day that he is no longer improving and he is actually regressing. On physical examination range of motion is 0-130 degrees. There is no posterior instability and no varus or valgus instability. The patient underwent Depomedrol injection on this date.

Initial request for 12 visits of physical therapy was non-certified on 06/11/15 noting that the clinical documentation submitted for review does provide evidence of significant objective functional improvement within the previous therapy provided. However, the guidelines recommend up to 24 visits of postsurgical ACL repair. There were no exceptional factors to warrant additional visits beyond the guidelines' recommendation as the patient has already completed 38 sessions of physical therapy. Additionally, the clinical note lacks evidence of significant objective functional deficits to warrant additional physical therapy. The patient should be well versed in a home exercise program. The denial was upheld on appeal dated 06/25/15 noting that patient underwent ACL reconstruction on 02/12/15 and has completed 38 physical therapy visits to date. Current evidence based 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.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient sustained an injury to the left knee on xx/xx/xx and subsequently underwent left knee ACL reconstruction and partial excision medial meniscus tear on 02/12/15. The submitted records report that the patient has completed 38 postoperative physical therapy visits. The Official Disability Guidelines recommend up to 24 postoperative physical therapy visits for the patient's diagnosis. There is no rationale in the submitted clinical information to support continuing to exceed this recommendation given the number of visits completed to date. Exceptional factors of delayed recovery to support exceeding ODG recommendations are not provided. Given the extensive nature of physical therapy completed to date, the patient should be well-versed in and encouraged to perform an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for physical therapy 3 x 4, 12 visits 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 and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

