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DATE NOTICE SENT TO ALL PARTIES: Jun/08/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: PT 2xWk x 6Wks Left wrist

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified General 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 PT 2 x wk x 6 wks left wrist 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 injured worker was assisting to move a x when the x came down on her left wrist. MR arthrogram of the left wrist on 01/09/15 revealed wide mouth radial tear of the central articular disc of the TFCC including its radial attachment, measuring approximately 3 mm, synovitis of the DRUJ without osteoarthritis or evidence of DRUJ instability, mild tenosynovitis ECU sheath without ECU tendon tear or subluxation. The patient underwent left wrist arthroscopy with TFCC debridement and sixth dorsal compartment debridement on 02/19/15. The patient has completed 12 postoperative physical therapy visits to date. Repeat evaluation dated 05/05/15 indicates that pain level decreased from 10/10 to 6/10. On physical examination she has well-healed portal sites and a well-healed incision. There is no evidence of complex regional pain syndrome. She has no effusion.

Initial request for PT 2 x wk x 6 wks left wrist was non-certified on 05/14/15 noting that the Official Disability Guidelines recommend physical therapy in the amount of 14 visits over 12 weeks following postsurgical intervention for synovitis and tenosynovitis. The patient was instructed to continue her home exercise program. Additionally, there was no documentation of a physical therapy re-evaluation with measures of functional improvement and remaining functional deficit. There is no documentation from the physician as to why this additional therapy is needed. Appeal letter dated 05/15/15 indicates that in her most recent follow up visit, the patient reported significant improvement in her symptoms. Her pain was reduced from 10/10 to 6/10. The patient has made significant but incomplete improvement with therapy. The focus of additional physical therapy would be on progressive functional strengthening with emphasis on gripping and pinching. The denial was upheld on appeal dated 06/04/15 noting that the request for 12 additional sessions would exceed the guideline recommendations. There are no exceptional factors present which would demonstrate the need for continued physical therapy beyond the guideline recommendations.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent left wrist

arthroscopy with TFCC debridement and sixth dorsal compartment debridement on 02/19/15 and has completed 12 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 14 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 PT 2 x wk x 6 wks left wrist is not recommended as medically necessary and 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)