

Core 400 LLC

An Independent Review Organization
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DATE NOTICE SENT TO ALL PARTIES: Feb/22/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Physical Therapy 3x3 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, 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 physical therapy 3 x 3 weeks is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is XX/XX/XX. The patient reports that she twisted her left ankle and almost fell. Physical therapy initial evaluation indicates that the patient complains of 7/10 ankle pain. On physical examination left ankle range of motion is dorsiflexion 4, plantar flexion 40, inversion 30 and eversion -5 degrees. Strength is 2+/5 dorsiflexion, 3+/5 plantar flexion, 4-/5 inversion and 0 eversion. Diagnosis is left ankle sprain. Physical therapy re-evaluation indicates that the patient has completed 3 of 6 authorized physical therapy visits. The patient reports that she continues to have 6/10 left lateral aspect ankle pain with increased difficulty standing and walking. On physical examination range of motion is dorsiflexion 5, plantar flexion 38, inversion 35 and eversion -5 degrees. Strength is unchanged. Physical therapy re-evaluation dated XX/XX/XX indicates that the patient has completed her six authorized physical therapy visits. She continues to have 6/10 left ankle pain. On physical examination left ankle dorsiflexion is 6, plantar flexion 39, inversion 35 and eversion -5 degrees. Strength is 3-/5 dorsiflexion, 4-/5 plantar flexion, 4/5 inversion and 0/5 eversion.

Initial request for physical therapy 3 x 3 weeks was non-certified on XX/XX/XX noting that only one note was provided for review which is a physical therapy note dated XX/XX/XX. The extent to which prior physical therapy has been beneficial is not adequately stated. Will need updated MD and physical therapy notes with detailed, objective and comparative physical examination findings and documentation of claimant's objective response to prior physical therapy to adequately review and support the request for additional physical therapy. Letter of medical necessity dated XX/XX/XX indicates that the patient was asked by her doctor to continuously use her Cam boot for walking. The patient has obviously continued to have increased left ankle weakness with functional deficits. She continues to ambulate with a Cam boot per doctor's orders. The patient has made minimal progress with physical therapy, but her progress will be slow. The denial was upheld on appeal dated XX/XX/XX noting that the request for an additional 9 sessions of physical therapy exceeds the guideline recommended 9 visits. In addition, the documentation submitted for review failed to provide functional improvements with the previous 6 physical therapy sessions to warrant the request for additional physical therapy. Furthermore, the documentation failed to provide evidence of

extenuating circumstances to warrant additional physical therapy over 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 left ankle sprain on XX/XX/XX and has completed 6 physical therapy visits to date. The Official Disability Guidelines support up to 9 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 submitted physical therapy records indicate that the patient has made minimal progress with physical therapy completed to date. Given that the patient did not progress significantly with a six visit clinical trial and the current request exceeds guidelines with no exceptional factors documented, medical necessity is not established for additional physical therapy. As such, it is the opinion of the reviewer that the request for physical therapy 3 x 3 weeks 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 KNOWLEDGBASE

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)