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: Mar/10/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: work conditioning 5 x wk x 2 wks - 30 hours

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

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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 <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for work conditioning 5 x wk x 2 wks - 30 hours is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient is a x and noted pain with swelling of the knee. The patient is status post left knee medial meniscectomy on 07/22/14. Functional capacity evaluation dated 12/09/14 indicates that required physical demand level is very heavy and current physical demand level is heavy. Progress note dated 01/08/15 indicates that the patient's pain is controlled. The patient still has difficulty with squatting and lateral agility. Current medications are Coreg and naproxen. Physical examination of the left lower extremity revealed the thigh is non-tender to palpation. There is mild medial joint line tenderness. Range of motion is 0-120 degrees. There is good quad control. Apley and grind test are negative.

Initial request for work conditioning 5 x wk x 2 wks 30 hours was non-certified on 12/26/14 noting that the patient is 5 months status post left knee arthroscopy. The physical examination reveals small effusion, full range of motion and no significant abnormalities noted. There is insufficient evidence to support a work conditioning program. Medical treatment guidelines authorize up to 12 sessions of physical therapy postoperatively. There is no reason why the patient cannot continue these exercises in a home exercise capacity. The denial was upheld on appeal dated 01/20/15 noting that there is no specific job description made available and. The functional capacity evaluation noted pain level is 0/10. Strength is 5/5 and range of motion is full.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent left knee medial meniscectomy on 07/22/14 and has completed an unknown number of postoperative physical therapy visits. Per functional capacity evaluation, the patient's strength is 5/5 in the lower extremities and range of motion is full. Pain level is 0/10. There is no clear rationale provided to support work conditioning which amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs), per the Official Disability Guidelines. It is unclear why a structured home exercise program is insufficient to address any remaining deficits. As such, it is the opinion of the reviewer that the request for work conditioning 5 x wk x 2 wks - 30 hours 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)