



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 12/13/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include the medical necessity of physical therapy treatments 3 x 4 weeks (12 total visits).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The reviewer is a Doctor of Chiropractic who is licensed in the State of Texas and has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination on all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr., Dr., Services and Dr..

These records consist of the following: Dr.: daily treatment notes from 7/16/07 through 10/19/07, 7/31/07 operative report, patient intake info, 7/5/07 initial report, SOAP notes Dr. 7/6/07 to 10/05/07, rehab notes by Dr. 8/8/07 to 8/23/0, various TWCC 73's and 10/18/07 venous Doppler report.

Services (in addition to any previously mentioned records): preauth request of 10/18/07, 10/12/07 exam, request for reconsideration preauth, 9/25/07 FCE, SOAP notes by 8/1/07 to 10/3/07, right knee MRI of 7/5/07, PT script, DO, notes 3/12/07, copy of ODG guideline (2 pgs) of lower extremity PT, 10/25/07 denial letter and 11/5/07 denial letter.

Dr. (in addition to any previously mentioned records): notes Dr. to 10/19/07 and SOAP notes by Dr. 10/5/07 to 10/12/07.

We did receive a copy of the ODG from the URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient's clinical history is that of a work related injury while employed . The records indicate he is employed as a at a medium duty position. The most recently provided FCE was from September of 2007 which rated him at a minimum of medium PDL on each measured task (he measured medium-heavy on several).

He has had approximately 18-24 prior active therapeutic sessions with Dr. and Dr.. The patient continues to complain of severe pain and is limited in ADL's due to his perceived pain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The reviewer notes that the patient has undergone a significant amount of rehabilitation that should have been able to provide adequate treatment for a medial meniscus repair and chondromalacia patella debridement. The records indicate that 1/3 of the meniscus was removed which is classified as a partial meniscectomy. The ODG indicates that partial meniscectomies require less intensive care than does a full meniscectomy (Meniscectomy): 12 visits over 12 weeks); therefore, based upon the ODG recommendations and the patient's apparent lack of progress with the proposed treatment plan in the past. This requested care is denied as not medically indicated at this time. This is not to say that requested care in the future is not necessary, rather that the currently proposed care is not indicated at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)**