

# **RYCO MedReview**

## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 04/30/08

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

12 sessions of physical therapy to the right knee

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

Board Certified in Orthopedic 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 or not medical necessity exists for each of the health care services in dispute.

12 sessions of physical therapy to the right knee - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations with M.D. dated 01/29/08 and 03/11/08  
DWC-73 forms from Dr. dated 01/29/08, 02/12/08, and 03/11/08  
An MRI of the right knee interpreted by M.D. dated 02/04/08  
Referral forms from Dr. dated 02/12/08 and 03/11/08  
An evaluation and physical therapy with M.P.T. dated 02/13/08  
Physical therapy with D.P.T. dated 02/19/08, 03/04/08, and 03/17/08  
Physical therapy with Mr. dated 02/21/08, 02/26/08, 02/27/08, 03/05/08,  
03/06/08, 03/10/08, and 03/19/08  
Physical therapy with an unknown therapist (signature was illegible) dated  
02/22/08 and 02/28/08  
A letter of denial, according to the ODG, from M.D. dated 03/19/08  
A PLN-11 form from the insurance carrier dated 03/20/08  
Letters of non-authorization, according to the ODG, dated 03/31/08 and 04/10/08  
On 04/04/08, P.T. wrote a reconsideration request note  
A letter of non-certification, according to the ODG, from M.D. dated 04/07/08  
A Notice of Assignment of IRO form dated 04/11/08  
An undated preauthorization request form  
The ODG Guidelines were not provided by the carrier or the URA

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

On 01/29/08, Dr. performed a knee injection and recommended Celebrex and an MRI. An MRI of the right knee interpreted by Dr. on 02/04/08 revealed evidence of an anterior cruciate ligament (ACL) allograft repair. Physical therapy was performed with Ms. on 02/19/08, 03/04/08, and 03/17/08. Physical therapy was also performed with Mr. from 02/21/08 through 03/19/08 for a total of seven sessions. On 03/11/08, Dr. performed another knee injection. On 03/19/08, Dr. wrote a letter of non-authorization for 12 sessions of physical therapy. On 03/20/08, the insurance carrier denied a left knee injury. On 03/31/08 and 04/10/08, wrote letters of denial for 12 sessions of physical therapy. On 04/04/08, Mr. wrote a reconsideration request for further treatment. On 04/07/08, Dr. also wrote a letter of non-certification for the physical therapy.

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

The requested 12 sessions of physical therapy are neither reasonable nor necessary. The ODG specifies that further therapy would only be necessary in limited circumstances. The patient had an old ACL tear in the same knee and did not apparently sustain any acute injury in the new MRI. Therefore, at this time, 12 sessions of physical therapy to the right knee would not be reasonable or necessary.

#### **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)