

Notice of Independent Review Decision

DATE OF REVIEW: 08/12/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3X a week for 5 weeks

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

The TMF physician reviewer is a licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the physical therapy 3X a week for 5 weeks is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Letter of determination– 07/02/08, 07/18/08
- Letter with history and physical examination by Dr. – 07/08/05, 04/25/08, 06/26/08
- Clinic notes by Dr. – 05/16/08 to 06/17/08

- Treatment history of physical therapy – 07/06/05 to 06/26/08
- Notice of assignment of IRO – 07/28/08
- Report of MRI of the right knee – 08/16/05
- Operative note by Dr. – 09/06/05, 04/17/08
- Information for requesting review by an IRO – 07/25/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he caught his right foot in recently poured asphalt and fell forward injuring his right knee. He received several weeks of physical therapy. An MRI of the right knee performed on 08/16/05 revealed a tear of the posterior horn of the medial meniscus. The patient underwent surgery on 09/06/05 after which he received an aggressive postoperative rehabilitation program as well as a work hardening program. Additional surgery was performed on 04/17/08 for a right knee recurrent tear of the medial meniscus with adhesions and chondral lesion of the trochlea. . He was treated with 12 post operative visits of physical therapy. The treating physician is requesting additional physical therapy 3X a week for 5 weeks.

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

This patient has undergone a large amount of physical therapy prior to his first surgery in xxxx as well as post surgical. After this most recent surgery, he has had 12 therapy visits. The ODG guidelines mentioned below only allow for postsurgical (meniscectomy): 12 visits over 12 weeks. The patient has received those visits. This patient should have been thoroughly instructed in an active self-directed home physical therapy at some point since his initial injury date of 07/05/05 as well as after this most recent surgical intervention. There is no clinical documentation or justification for continued in-office supervised physical therapy. The ODGs as well as other national treatment guidelines do not allow for additional therapy beyond the 12 visits for a postsurgical (meniscectomy).

ODG Physical Therapy Guidelines-

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical therapy. There are also other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface. Post-surgical (meniscectomy): 12 visits over 12 weeks.

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)