

MEDICAL REVIEW OF TEXAS

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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 19, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional postoperative physical therapy 3 times a week for 4 weeks.

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

MD, 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. January 9, 2008 – a non-certification of services/procedures from, LVN. Undated second letter from RN.
2. Pain Care and Rehabilitation – initial physical therapy evaluation December 12, 2007. Physical therapy reevaluation December 28, 2007. Request for reconsideration of additional physical therapy January 11, 2008. All of these were written by PT.
3. MD – evaluation October 24, 2007. Operative report from November 27, 2007. Evaluation December 3, 2007, with a prescription for physical therapy from that date. Evaluation December 18, 2007. Prescription for additional

physical therapy and a Medrol Dosepak from January 9, 2008. Office visit January 9, 2008, was reviewed.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a woman employed as a . She fell at work and landed directly on her right knee. She also sustained a blow to her left elbow. X-rays, MRI and bone scan were all compatible with a chondral fracture involving the undersurface of the patella. Nonsteroidal anti-inflammatory medications were not helpful.

She was initially seen by M.D., on 10/24/07, complaining of persistent limping, buckling of her knee, and night pain. She also had persistent left elbow pain.

Dr.'s physical examination revealed no definite patellofemoral malignancy, but there was apprehension and tenderness to manipulation of the patella. No other knee abnormalities were noted on examination, except for a minimal knee effusion.

Left elbow examination revealed there to be tenderness in the area of the lateral condyle with pain aggravated by wrist dorsiflexion against resistance.

Dr. diagnosed chondral or osteochondral fracture of the right patella and lateral epicondylitis of the left elbow. Because of prolonged symptomatology, he recommended right knee arthroscopic surgery and he also injected the lateral epicondyle area of the left elbow.

The patient was taken to the operating room by Dr. on November 27, 2007. The arthroscopic findings included an attrition tear of the posterior horn of the medial meniscus and grade III to IV chondromalacia of the patella. A partial medial meniscectomy, chondroplasty of the patella, and patellar lateral retinacular release were performed, as well as a partial synovectomy.

Postoperatively, the patient was seen on 12/3/07, and physical therapy 3 times per week for 3 weeks was ordered. When the patient was last seen by Dr. on 1/9/08, the knee was showing "definite improvement". The patient was returned to work at light duty. Further physical therapy 3 times a week for 3 weeks was ordered.

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

ODG Guidelines indicate that the diagnosis of chondromalacia patella, dislocation patella and derangement of meniscus all warrant 9 visits of physical therapy over 8 weeks plus active self-directed home physical therapy. At the time of the last physical therapy evaluation on 12/28/07, this patient had had 6 physical therapy visits. When last seen by Dr. on 1/9/08, presumably she had the additional 3 visits that were initially ordered. Both the therapist's notes and

Dr.'s records indicate that the patient had a good response to therapy. No compelling reason for additional physical therapy was offered in the records presented for review. Appropriate further treatment would be a home self-directed physical therapy program.

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)**