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DATE OF REVIEW: 01/15/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy three times a week for four weeks

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery.

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Physical therapy Three times a week for four weeks	97110, 97002, 97530, 97140, 97124, 97035, G0283	Upon approval	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Documentation:	Date:
Office Visit –MD – Orthopedic Care Center	03/23/07
MRI Left knee –Diagnostic Imaging	04/04/07
Office Visit –MD – Orthopedic Care Center	05/09/07
Office Visit –MD - Orthopedic Care Center	08/13/07
Operative Report –MD – Orthopedic Care Center	10/01/07
Office Visit - MD – Orthopedic Care Center	10/11/07
Referral forms for physical therapy - MD – Orthopedic Care Center	10/15/07 11/19/07
Post Operative Office Visit –MD - Orthopedic Care Center	10/15/07
Physical Therapy Initial Evaluation –PT- Pain Care & Rehabilitation	10/29/07
Physical Therapy Notes –Pain Care & Rehabilitation Center	10/07 (no specific dates noted) 11/05,06,09,12,15,20 12/07 (no specific dates noted)
Physical Therapy Rehabilitation –PT - Pain Care & Rehabilitation Center	11/19/07

Utilization Review Request – Physical Therapy - Pain Care & Rehabilitation Center	11/21/07
Utilization Review Physician Determination – MD	11/27/07
Utilization Review Determination – Adverse determination – Physical Therapy – ODG Criteria and citation information included -	11/29/07
Utilization Review Appeal Request – Physical Therapy - Pain Care & Rehabilitation Center	11/29/07
Office Visit & Work Status Report –MD - Orthopedic Care Center	12/03/07
Utilization Review Physician Determination –MD	12/04/07
Utilization Review Determination for approval of 1 physical medicine session to train for a home exercise program –	12/07/07
Utilization Review Physician Determination –DO	12/13/07
Utilization Review Appeal Determination – Adverse determination – Physical Therapy – ODG Criteria and citation information included -	12/18/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx year old female who tripped over a rolled rug at work sustaining an abrasion to the right knee and contusion to the right elbow and injured left knee. Injury date was xx/xx/xx. The patient had left knee arthroscopic partial medial meniscectomy on 10/01/07. She had 25 physical therapy sessions post-operatively and 35 physical therapy sessions preoperatively for a total of 60 sessions since March 2007.

An MRI revealed a tear of the medial meniscus and an osteochondral defect in the medical femoral condyle. On 11/19/07 her knee ROM was -5 degrees to 110 degrees and had a 4/5 muscle strength.

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

Regardless of which guideline one adheres to, the post-arthroscopic medial meniscectomy physical therapy guidelines have been exceeded. The patient has had 25 physical therapy sessions post-arthroscopic medial meniscectomy which are more than twice the perimeters of evidence-based medicine guidelines recommendations.

Based upon the referenced peer reviewed evidence-based guidelines, the request for 12 more P.T. sessions are non-certified.

ODG, 4th ed, p 671, 2006 indicates that controversy exists about the effectiveness of physical therapy after arthroscopic partial medial meniscectomy. ODG, 11th ed, 2006 states that 9 sessions of physical therapy over 8 weeks along with a self directed home exercise program (HEP) after arthroscopic medial meniscectomy are appropriate. The ODG web-based 12th ed., recommends 12 sessions over 12 weeks beginning 3x/week fading to once/week with a self-directed HEP for post-surgical meniscectomy.

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

ODG:

ODG, 11th ed, 2006 and ODG, web-based 12th edition

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: the Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 01/15/2008.

