

# US Decisions, Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 07/08/08

**IRO CASE #:**

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

Physical Therapy three times a week for four weeks for left knee consisting of 97110, 97530, 97112, 97010, 97035, 97014, 97113.

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

M.D., Board Certified Orthopedic Surgeon

### **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)

Upon independent review the reviewer finds that the requested Physical Therapy three times a week for four weeks for left knee consisting of 97110, 97530, 97112, 97010, 97035, 97014, 97113 is not medically necessary.

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

Adverse Determination Letters 6/13/08, 4/16/08, 4/14/08

ODG Guidelines and Treatment Guidelines

MD 2008 5/22, 5/12, 4/1, 3/17, 2/29, 1/18, 1/14, 1/7

MD 2007 12/13, 11/29, 11/15, 11/2, 10/23, 10/16, 10/9, 9/27, 5/1, 3/9, 1/23

MD 2006 12/19, 11/28, 11/9, 11/3, 11/1, 10/27, 10/16, 8/25

MD 2005 7/5, 6/3, 4/26, 3/15

Pre-Authorization Requests 4/9/08, 6/4/08

Physical Therapy Re-Evaluations 4/1/08, 6/2/08  
Physical Therapy Referral 5/22/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a xx year old injured worker who has undergone tibial tubercle transfer for realignment of her patella tendon and extensor mechanism. She has had previous physical therapy, ten sessions, and there is a request for further therapy. Office Visit of 01/23/07 as well as office visits of 2006 indicate similar findings of her being postoperative surgery on the knee with patellar tendon transfer. However, it is difficult for us to determine what her current status is concerning the request for left knee therapy. We do know when she had her right knee surgery, she did well based upon her March 2007 office visit. Based upon a 01/07/08 office visit, she was scheduled at that time for left knee patellar realignment surgery and apparently underwent this. On 01/14/08 she was three days postoperative, which now places her at six months post surgery. She has had some postoperative therapy according to one reviewer, apparently ten postoperative treatments. The postoperative notes from the surgeon indicate she has done well. On 05/12/08 the surgeon recommended to see her back and place her at MMI and full duties. The previous reviewer noted that there were not records current from the treating physicians indicating the need for further physical therapy. The current request is for Physical Therapy three times a week for four weeks for left knee consisting of 97110, 97530, 97112, 97010, 97035, 97014, 97113.

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

Upon independent review of the provided medical records and ODG Guidelines, this reviewer finds that the requested Physical Therapy three times a week for four weeks for left knee consisting of 97110, 97530, 97112, 97010, 97035, 97014, 97113 is not medically necessary.

The previous reviewer noted that there were not records current from the treating physicians indicating the need for further physical therapy. However, given the fact it has been six months since the surgery, the ODG Guidelines and general medical clinical experience and judgment would not support further formal physical therapy.

Given the fact that the patient is now six months post surgery and has had postoperative physical therapy and is past any acute or subacute period for which the physical therapy may be of benefit, the previous reviewer's adverse determination has been upheld due to the lack of medical necessity for this formal physical therapy in this stage of the treatment 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)