

US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

Notice of Independent Review Decision

DATE OF REVIEW: JULY 10, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy, 3x/week x 4 weeks

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

MD, 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)

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.

The reviewer finds that medical necessity does not exist for Physical Therapy, 3x/week x 4 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 6/16/08, 5/20/08
ODG Guidelines and Treatment Guidelines, Physical Therapy
Letter to IRO, 6/27/08
CAS Notices, 2/26/08, 5/19/08, 2/25/08
MRI Right Knee, 1/15/08
Second opinion of MRI Right Knee, 3/4/08
, 5/23/08, 5/13/08
Operative Report, 4/28/08
, MD, 4/26/08, 4/16/08, 3/19/08, 2/6/08, 6/4/08
, MD, 3/21/08
Daily SOAP Notes, 1/23/08, 1/17/08, 1/15/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker who was injured playing basketball while in the scope and course of employment on xx/xx/xx. She apparently sustained a meniscal tear of the right knee. She underwent a meniscectomy of the right knee on 04/28/08 with some indication of atrophic changes of the vastus medialis. She has had twelve post meniscectomy skilled therapy sessions, and there is a request for further therapy.

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

This patient has undergone an uncomplicated meniscectomy. Although her work description requires a level of fitness not commonly seen in the injured worker, the patient has already received the amount of formalized skilled therapy sessions recommended by the Official Disability and Treatment Guidelines. The current request would exceed the guidelines, and it is for this reason that the reviewer finds that medical necessity does not exist for Physical Therapy, 3x/week x 4 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
- AHCP- 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)**