

## **I-Resolutions Inc.**

*An Independent Review Organization*

71 Court Street

Belfast, Maine 04915

(512) 782-4415 (phone)

(512) 233-5110 (fax)

### Notice of Independent Review Decision

**DATE OF REVIEW: JUNE 22, 2008**

**IRO CASE #:**

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

Physical therapy 3 times a week for 4 weeks, right knee.

**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)

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 there is not medical necessity for physical therapy three times per week for four weeks for the right knee.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 5/22/08, 5/16/08

ODG Guidelines, Physical Therapy

MD, 5/5/08, 4/7/08, 3/17/08, 3/3/08

PTA, 5/6/08, 5/20/08, 4/4/08, 4/2/08, 3/31/08, 3/26/08, 3/24/08, 3/21/08, 3/20/08

Therapy Referral, Orthopedic Surgery Group

MD, 5/12/08

PT, 3/12/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a male who was involved in an accident at work in xx/xx. He injured his right knee. He has a diagnosis of sprained anterior cruciate ligament, grade 1. He has had physical therapy. He was recently seen, at which time it was stated he was much improved and had returned to full duty and basically had progressed extremely well.

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

The ODG Guidelines do not support further physical therapy for this injured worker. He has already had sufficient physical therapy with documented excellent outcome. He has already accessed twelve physical therapy treatments. Any further therapy would exceed the guidelines. For this reason the reviewer finds that there is not medical necessity for physical therapy three times per week for four weeks for the right knee.

**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
- AHCPH- 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)