



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 5/21/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of 12 sessions of Pt to right knee to include therapeutic exercises, treatment for strength, and movement recovery and manual therapy. (97110 & 97140)

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

The reviewer is a medical doctor who is board certified in Physical Medicine and Rehabilitation.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of 12 sessions of Pt to right knee to include therapeutic exercises, treatment for strength, and movement recovery and manual therapy. (97110 & 97140)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

Group
Bone & Joint Clinic- MD
Physical Therapy- PT

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Group: letter-5/8/08; Group denial letters-

4/15/08 & 4/23/08; Solutions Peer Review Reports-4/14/08 & 4/22/08; Physical Therapy preauthorization request-4/10/08, reconsideration request-4/18/08, Daily note-4/2/08 – 4/21/08, and Progress Note-4/11/08; and MD Therapy Prescription Form-4/9/08.

Records reviewed from Bone & Joint Clinic- MD: Initial examination-1/29/08, Follow-up examination-2/27/08-4/9/08; Certificate of Medical Necessity and Prescription-4/17/08, and Operative Report-2/19/08; MD report-10/23/07, 8/2/07, and 1/22/08; Medicine Health Event Report-4/10/08; Range of Motion chart- 2/21/08 – 4/8/08; and Physical Therapy prescription-3/19/08.

Records reviewed from Physical Therapy-, PT: Progress notes-4/11/08 and Pt Letter of Medical Necessity-4/18/08

A copy of the ODG was not provided for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured at work. He underwent a right knee scope with ACL repair using autograft and chondroplasty in 8/07. This was followed by manipulation under anesthesia on 10/07. He then underwent right knee arthroscopy with ACL revision, plicaectomy, chondroplasty, and partial medial meniscectomy on 2/19/08. Physical therapy was recommended by Dr. 14 post-operative (most recent procedure) PT encounters are documented.

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

According to the ODG, a post-operative PT program is recommended. Sprains and strains of knee and leg; cruciate ligament of knee (ACL tear) (ICD9 844; 844.2)...Post-surgical (ACL repair): 24 visits over 16 weeks.

The reviewer states that since the patient injured his knee, he has undergone two procedures. This was followed by right knee arthroscopy with ACL revision, plicaectomy, chondroplasty, and partial medial meniscectomy on 2/19/08. There is documentation that 14 visits of PT have been completed after the most recent procedure. Twelve more sessions are being requested which is in excess of the ODG guidelines, which would allow only 10 more, therefore the requested 12 sessions are not medically necessary.

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)**