

# Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

**DATE OF REVIEW:** October 16, 2008

**IRO CASE #:**

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

Medical necessity of 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**

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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Office notes, PA-C, 03/05/08, 04/29/08, 05/27/08, 07/21/08, 08/27/08

MRI right knee, 03/26/08, 06/24/08

Office note, Dr. , 03/38/08

OR note, 07/10/08

Physical therapy notes, 07/23/08-08/15/08, 08/15/08 – 08/24/08, 08/27/08, 08/29/08

Peer review, Dr. , 08/28/08

Office notes, Dr. , 06/10/08, 09/24/08

Peer review, Dr. , 09/25/08

Work Status, 04/29/08, 05/27/08, 07/21/08

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a xx year old male who injured his knee on xx/xx/xx. He failed to respond to conservative measures and a repeat MRI showed a medial meniscus tear. On 07/10/08 the claimant had an arthroscopic right knee partial medial meniscectomy, chondroplasty with abrasion and microfracture of the patella (minimal and superficial) and medial compartment.

Therapy was initiated on 07/23/08. Records provided would support that the claimant had 14 visits of therapy following surgery.

On 09/24/08 Dr. reported the claimant still had weakness of the quadriceps with difficulty on stairs or with squatting. The examination documented good motion, a stable knee and minimal swelling. Pain was felt to be patellofemoral femoral and 4 weeks therapy were recommended.

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

The ODG guidelines would recommend 12 visits of therapy after arthroscopic meniscectomy. Although the exact number of physical therapy visits in this case is unclear, it would certainly appear that there were 6 visits between 07/23/08 and 08/15/08 and another 6 visits between 08/15/08 and 08/24/08. As such, this person appears to have met the recommended number of visits per the ODG guidelines. There are no specific findings in the medical records which would allow the reviewer to suggest that an additional 12 visits are needed.

Official Disability Guidelines Treatment in Worker's Comp 2008, Physical therapy Preface and Knee-Physical Medicine

**Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella** (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5):

Medical treatment: 9 visits over 8 weeks

Post-surgical (Meniscectomy): 12 visits over 12 weeks

#### **Physical Therapy Preface**

Unless noted otherwise, the visits indicated are for outpatient physical therapy, and the physical therapist's judgment is always a consideration in the determination of the appropriate frequency and duration of treatment

While the recommendations for number of visits are guidelines and are not meant to be absolute caps for every case, they are also not meant to be a minimum requirement on each case (i.e., they are not an "entitlement").

### **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)**