

SENT VIA EMAIL OR FAX ON
Feb/23/2009

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/23/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 3 X 4

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

physical therapy note 01/05/09

Office note Dr. 01/06/09

Note from 01/15/09

Note from 01/29/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx year old male who had an anterior cruciate ligament reconstruction, medial meniscus repair and lateral meniscectomy xx/xx/xx.

A 01/05/09 therapy report indicated the claimant started therapy on 10/13/08 and was most recently seen 12/08/08. The claimant reported continued left knee pain that was worse for 2 weeks, minimal swelling but difficulty squatting and with stairs. On the examination there was minimal to no swelling and minimal to no atrophy. Motion was 0-110 degrees and the therapist noted poor VMO contraction and sequencing. There was no extensor lag, or laxity and he had a good quadriceps set.

On 01/06/09 Dr. felt the claimant had regressed in motion. X-rays showed no fracture and good placement of hardware. Dr. recommended additional therapy.

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

The medical records do not demonstrate a clear reason why physical therapy should continued in the perioperative period for an anterior cruciate ligament reconstruction. He has had 30 sessions so far for an anterior cruciate ligament reconstruction, medial meniscus repair, and partial lateral meniscectomy. This exceeds the recommendations of ODG for post surgical visits for these procedures. There are no documented complications to necessitate additional formal therapy.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)