

SENT VIA EMAIL OR FAX ON  
Dec/02/2009

## Applied Assessments LLC

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Nov/25/2009

**IRO CASE #:**

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

Physical Therapy 3 X 4 left knee

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC SURGERY

**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

Denial Letters 10/6/09 and 10/19/09

Dr. 8/10/09 thru 11/9/09

Medical Centers 6/5/09 thru 9/29/09

**PATIENT CLINICAL HISTORY SUMMARY**

This woman was injured xx/xx/xx. Dr. saw her on 6/5/09 and states that there was no fracture on the xrays. Dr. described a radiology report as showing mild patella spurring without any fracture. She was felt to have a contusion and was treated with medications and restricted motion and a knee immobilizer. The therapy notes of 9/29/09 described her complaints of aching and throbbing pain. The therapist described an antalgic gait, some

weakness (4+), "mild tenderness" at the patella and 135 degrees of active flexion with full active extension. The therapist described that the xrays were "negative per medical provider." Dr. wrote several times of an MRI done 7/22/09 that showed a nondisplaced comminuted fracture of the inferior patella pole, a Baker's Cyst and chondromalacia. He advised 6 weeks of immobilization on 8/10/09. The immobilization stopped on 9/25/09. He wrote that she only had 120 degrees of active flexion on 10/26/09, improved from 80 degrees on 9/2/09. As noted she had 135 degrees of flexion by 9/29. He wrote she is unable to kneel.

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

This lady had a non-displaced patella fracture that was treated appropriately with immobilization. She has ongoing patella pain. The Reviewer is unclear from the material if the pain is retropatella or anteropatella. The kneeling pain may be from the chondromalacia patella described. This will not likely improve to permit kneeling after therapy, although the range of motion may improve. At the same time, the ranges of motion vary, although they are generally improving. The ODG allows for 10 therapy sessions over 8 weeks. These are fewer sessions permitted over a longer period of time and this includes a home program. The reduced time frame of 4 weeks of therapy requested could be justified since the fracture is 5 months old and the lady obviously has good motion as described in the records. However, the Reviewer did not see justification for the need for thrice weekly therapy. Rather a program with some initial supervision followed by a home/self directed program, as recommend in the ODG, is what would be approved. Since the Reviewer is only allowed to approve or deny what is requested, the Reviewer finds that they cannot justify the 12 therapy sessions at this time based upon the ODG.

**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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES

**(PROVIDE A DESCRIPTION)**