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Notice of Independent Review Decision

DATE OF REVIEW: 10/01/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Twelve visits of physical therapy

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

Board Certified in Orthopedic 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)

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.

Twelve visits of physical therapy - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with D.C. dated 07/22/08, 08/05/08, 08/15/08, 09/16/08, 10/16/08, 11/13/08, 12/03/08, 12/23/08, 01/05/09, 01/15/09, 01/19/09, 02/09/09, 03/09/09, 05/27/09, 06/26/09, 07/27/09, and 08/24/09

MRIs of the right knee interpreted by M.D. dated 07/30/08 and 12/18/08
Evaluations with M.D. dated 08/25/08, 10/15/08, 11/12/08, 12/17/08, 01/14/09, 02/11/09, 03/18/09, 04/20/09, 05/27/09, 06/29/09, and 07/29/09

Operative reports from Dr. dated 10/09/08 and 02/05/09

Physical Performance Evaluations (PPEs) with Dr. dated 01/20/09, 02/20/09, and 07/21/09

A precertification request form from Dr. dated 02/04/09

Chiropractic therapy with Dr. dated 04/30/09, 05/04/09, 05/11/09, 05/26/09, 06/01/09, 06/02/09, 06/17/09, 06/24/09, 06/29/09, 07/01/09, 07/03/09, 07/06/09, 07/08/09, 07/10/09, 07/13/09, 07/15/09, 07/17/09, 07/20/09, and 07/22/09

A DWC-73 form filed by Dr. dated 07/29/09

Letters of non-authorization, according to the Official Disability Guidelines (ODG), from Corporation dated 07/31/09 and 08/14/09

A letter from Attorneys at Law dated 09/17/09

The ODG criteria was not provided by the carrier or URA

PATIENT CLINICAL HISTORY

An MRI of the right knee interpreted by Dr. on 07/30/08 showed a horizontal cleavage tear of the mid-third segment of the lateral meniscus, status post a partial medial meniscectomy with horizontal cleavage tearing of the posterior horn of the medial meniscus remnant, and moderate chondromalacia of the medial compartment. On 10/09/08, Dr. performed an arthroscopy and removal of the posterior horn meniscus tear and midportion of the lateral meniscus tear. Another MRI of the right knee interpreted by Dr. on 12/18/08 showed ill-defined tibial attachment fibers of the anterior cruciate ligament (ACL) consistent with a previous partial tear, diffuse thickening and proximal half the posterior cruciate ligament (PCL) consistent with a previous tear, status post a medial meniscectomy, a horizontal cleavage tear and an adjacent radial tear in the lateral meniscus, and mild to moderate medial and lateral compartment osteoarthritis. On 02/05/09, Dr. performed an arthroscopy, medial partial meniscectomy, and removal of part of the lateral meniscus that was torn. Chiropractic therapy was performed with Dr. from 04/30/09 through 07/22/09 for a total of 19 sessions. On 07/31/09 and 08/14/09, wrote letters of non-certification for 12 sessions of physical

therapy. On 08/24/09, Dr. recommended a mental health evaluation and possible work hardening program.

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

The patient is now over xxxx months status post reported anterior cruciate ligament reconstruction. He would be expected at this point in the treatment program, according to the evidence based ODG, to be on a self directed home exercise program. He reportedly has undergone at least 60 sessions of physical therapy status post two knee surgeries to this knee. The ODG recommendation for sprains and strains of the knee and leg, to include the cruciate ligament of the knee, is 24 visits over 16 weeks. There is no medical indication, according to the ODG, for the requirement for additional physical therapy at this time and therefore, the requested 12 sessions of physical therapy would not be reasonable or necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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)**