

Notice of Independent Review Decision
IRO REVIEWER REPORT

DATE OF REVIEW: 08/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy for left knee pain – 12 visits

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

The TMF physician reviewer is board certified in physical medicine and rehabilitation with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the physical therapy for left knee pain – 12 visits is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 08/04/10
- Letter to TDI from attorneys – 08/04/10
- Decision letter from, Inc. – 02/18/09, 02/26/09, 07/13/09, 07/09/10, 08/03/10
- Letter to TMF from attorneys – 08/09/10
- Orthopedic evaluations by Dr.– 03/19/09 to 10/30/09
- Clinic visit notes by Dr.– 01/19/09 to 11/17/09
- PT progress notes from Rehab PT Dept. – 01/26/09 to 08/26/09
- Results of Residual Functional Capacity Battery – 08/26/09
- History and Physical with chart review by Dr.– 11/02/09
- Utilization review determination from, Inc. – 07/09/10
- Report of MRI of the Left knee – 01/31/09, 08/07/09
- Physical therapy evaluation form – 06/09/09
- Functional Abilities Evaluation – 11/02/09

- Operative note by Dr.– 05/20/09
- Patient evaluation by Dr.– 04/01/10
- Prescription for knee brace 02/04/09
- Report of chest x-ray – 05/13/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was working, exited the bus and stepped into a pot hole. This resulted in injury to the left knee. An MRI of the left knee indicated an oblique tear posterior horn medial meniscus with joint effusion. The patient is post arthroscopic partial medial meniscectomy and has been treated with physical therapy as well as the use of a hinged knee brace. The treating physician is recommending an additional 12 visits of physical therapy.

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

Based on ODG guidelines, this patient requires 12 sessions of physical therapy for progressive range of motion exercises, gentle prolonged stretching and gait training. Lastly he requires specific instructions regarding a home based program. The home based program will need to be established during sessions 11 and 12.

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 KNOWLEDGBASE
- AHCP- 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)

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