

US Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Physical Therapy 3 times per week for 4 weeks for right knee as outpatient

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines, Knee and Leg
Notices of Denial, Broadspire, 1/18/10, 1/22/10
Orthopaedic Surgery Group, 1/5/10, 1/12/10
MD, 1/25/10
MD, 1/19/10
MRI Right Knee, 12/2/09
FCE, 10/2/09

PATIENT CLINICAL HISTORY SUMMARY

He was injured on xx/xx/xx when he fell between a truck and a dock hitting his right knee. He subsequently underwent arthroscopic surgery on 05/21/09 when an acute tear of the anterior horn of the medial meniscus was found. He had 32 postoperative physical therapy visits but subsequently returned with ongoing pain in the patellofemoral region. A request was for additional physical therapy visits.

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

Based upon the Official Disability Guidelines and Treatment Guidelines, this claimant has already exhausted the recommended number of sessions of one-on-one physical therapy. If the diagnosis is indeed patellofemoral syndrome, then the guidelines would recommend self-directed home-based therapy at this juncture. There is no medical necessity for these exercises to be performed in a supervised manner. The reviewer finds that medical necessity does not exist for Additional Physical Therapy 3 times per week for 4 weeks for right knee as outpatient.

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)