

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3xWk x 4Wks left knee 97110 97530 97116 97113

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

M.D., 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

Peer Reviews dated 12/29/09, and 1/14/10

Physical Therapy: 12/16/09, 11/16/09, 10/20/09

Dr.: 12/9/09, 11/11/09, 10/14/09

Miscellaneous: 10/6/09

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates, Knee, Physical Therapy

PATIENT CLINICAL HISTORY SUMMARY

This male is status post a left knee replacement done on 9/29/09 with subsequent irrigation and debridement performed on 10/1/09. He was injured on xx/xx/xx and had surgery for a left knee popliteal cyst in January of 2009. To date he has had 24 visits of physical therapy.

Clinically, he has had continued effusion of the knee, and the therapist has indicated concern to the physician with regard to that. Dr. on 12/9/09 did aspirate the knee for about 40 cubic centimeters of serosanguineous fluid; the plan was for culture and sensitivity of the fluid. Active range of motion is from 0 to between 115 to 120 degrees of flexion, there is some quadriceps atrophy on the left lower extremity compared to the right, x-rays have documented good alignment without evidence of any loosening, he is ambulating without an assistive device, he is noted to have functional limitations in kneeling, squatting, ambulating long distances, and with descending stairs. The request for additional therapy has been previously denied on two occasions.

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

Request is for physical therapy three times a week for four weeks, left knee, status post left total knee replacement on 09/29/09 and irrigation and debridement on 10/01/09. At this time there are no records provided to support the medical necessity for additional physical therapy three times a week for four weeks to the left knee. The patient's range of motion was improving as of 12/09/09. That was 2 ½ months status post index surgery and six weeks status post irrigation and debridement. The patient has had 24 physical therapy sessions. Documentation was not provided to explain why the ODG should not be followed in this case. Consistent with evidence based medicine, and ODG guidelines, the reviewer finds that medical necessity does not exist at this time for Physical Therapy 3xWk x 4Wks left knee 97110 97530 97116 97113.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates, Knee, Physical 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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