

Clear Resolutions Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199A

Austin, TX 78726

Phone: (512) 772-4390

Fax: (512) 519-7316

Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 3xWkx 4 Wks Right Knee 97014 97035 97110 97113 97116 97124 97140

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

MD, Board Certified in Physical Medicine and Rehabilitation

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

Adverse Determination Letters, 3/12/10, 3/31/10

xxxxxxx 3/2/10, 2/26/10, 3/16/10

PATIENT CLINICAL HISTORY SUMMARY

This man injured his right knee when a ram fell and his knee buckled. He had an allograft reconstruction of the knee on xxxxx. This was followed by 24 sessions of physical therapy. The therapy note from 2/26/10 described no measurable atrophy. He had no laxity on manual testing. He had 0-110 degrees of motion. He walked without any assistive device, but had a limp and problems on stairs. He had pain in the right knee, but it was not described as to being anterior or deep in the knee. He has some weakness of the quadriceps.

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

This gentleman remains symptomatic with pain in the right knee. The records were unclear as to whether the pain was at the operative site, at the joint line, deep in the knee or retropatella. He has no atrophy, good strength and motion. The ODG allots 24 sessions of therapy over 16 weeks. This gentleman had 24 sessions over 2 months. There was nothing provided to explain why the therapy was concentrated in half the allotted time. The approved guidelines provide for a reduction in the frequency and more emphasis on a home or self directed program. Nothing was provided to explain why this was not performed. Absent this information, the reviewer cannot diverge from the ODG. The reviewer finds that medical necessity does not exist at this time for PT 3xWkx 4 Wks Right Knee 97014 97035 97110 97113 97116 97124 97140.

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)