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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 2xWk x 3Wks Right Knee 97530 97110 97035 97140

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

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates. Knee , 6/1/10, 7/9/10

Office notes, Dr., 3/12/10, 04/02/10, 04/30/10, 05/21/10, 06/11/10, 07/17/10, 07/30/10, 08/10/10

Operative report, Dr., 3/31/10

FCE, 5/6/10

Peer review, Dr., 6/1/10

Peer review, Dr., 6/9/10

Prescription, 6/11/10

Request, 6/23/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant with a reported work injury on xx/xx/xx when he was stepping down some steps and missed the last step and landed awkwardly on the right foot twisting his right knee. The claimant is 6'4" and 353 pounds. MRI showed a medial meniscus tear and on 03/31/10 Dr. performed arthroscopic partial medial meniscectomy of the right knee. The claimant completed twelve visits of post op therapy. A functional capacity evaluation on 05/06/10 demonstrated the capability of medium level work. The claimant had 4+/5 right quadriceps and hamstring strength.

On 05/21/10 Dr. documented quite a bit of knee pain and right calf pain with some tightness and swelling. On exam there was tenderness along the hamstrings and in the medial and lateral heads of the gastrocnemius. Homans caused calf pain. Range of motion was 8-110 degrees. The claimant had some tenderness along the medial and lateral patellar facets. The right anterolateral joint line was injected with lidocaine and Celestone. A Doppler of the right leg was ordered. Additional physical therapy was also ordered. However, the physical therapy was denied on peer review.

On 06/11/10 Dr. noted that the claimant was doing better but still had some tightness especially with deep knee bending. Range of motion was 0-120 degrees. There was trace swelling and moderate quadriceps atrophy. The claimant was released to part time light duty work. Additional therapy was again requested.

On 07/17/10 range of motion was 5-108 degrees with moderate quadriceps atrophy. The claimant was to continue modified duty. Another functional capacity evaluation was ordered.

On 07/30/10 Dr. noted that the claimant did quite well on the functional capacity evaluation and was able to lift up to 100 pounds. The claimant still had some low grade pain in the knee with activities. The therapist noted that the only areas of restrictions were crawling, kneeling, and squatting down. Range of motion was 0-120 degrees. The claimant was released to regular duty. The claimant was seen on xx/xx/xx because he had stepped off a curb at work the day before and put all his weight on the right side and had recurrent swelling and pain. On exam he had trace swelling and no tenderness and normal range of motion. The impression was right knee sprain status post meniscectomy.

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

Based on review of the records provided the reviewer finds that physical therapy two times per week for three weeks as medically necessary acknowledging that it falls slightly outside the standard Official Disability Guidelines. However given the recent sprain of the knee and documentation of mild restricted range of motion, and limitations at work which appears to be very heavy duty work, the additional therapy would be appropriate in order to further strengthen the knee and assist with return to full duty. According to the ODG preface, when treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. There are exceptional factors in this case, and therefore, the reviewer finds that medical necessity exists in this patient's case for Physical Therapy 2xWk x 3Wks Right Knee 97530 97110 97035 97140.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates. Knee. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530)

ODG Physical Medicine Guidelines

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface

Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee

Post-surgical (Meniscectomy): 12 visits over 12 weeks

ODG Preface:

When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.

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)