

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/22/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 2xWk x 3Wks

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

MD, 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

Peer Review, Dr. 02/28/11

Peer Review, Dr. 03/18/11

MR Arthrogram right knee, 06/24/10

X-rays right knee, 06/24/10

Operative Report, 07/08/10

Prescription, 07/14/10

Physical therapy initial evaluations, 07/26/10, 02/23/11

Daily physical therapy notes, 07/28/10 – 09/17/10, 10/22/10, 11/10/10, 02/25/11

Physical therapy re-evaluation, 10/22/10

Office Visits, Dr., 10/28/10, 02/21/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is status post a right knee arthroscopic partial lateral meniscectomy and abrasion arthroplasty performed. The postoperative diagnoses included: a right knee lateral meniscus tear and grade-3 arthritis. Physical therapy was started on 07/26/10 and continued through to 10/22/10; he attended 10 visits. A physical therapy re-evaluation on 10/22/10 noted poor compliance. Active motion of the right knee was flexion 115 degrees and extension minus 5 degrees. Strength of the right knee was flexion 3/5, extension 3-/5. Dr. saw the claimant on 10/28/10 and noted some improvement in the knee with some inflammation, which was felt to be due to arthritis. The knee was injected with Kenalog and Marcaine. Another therapy visit was provided on 11/10/10.

The records lapse then until a 02/21/11 re-evaluation with Dr. At the 02/21/11 visit it was noted that he had grade-3 arthritis, which had flared back up. There was some inflammation. The knee was again injected with Kenalog and Marcaine. Therapy was restarted on 02/23/11

for weakness in the right knee and intermittent difficulty with the knee that had not allowed him to fully rehabilitate. He reported pain and tenderness with referred pain down the right calf and up to the mid thigh. Atrophy and edema were noted. He was wearing a right knee brace. Active motion of the right knee was: flexion 103 degrees, extension minus 4 degrees. Strength was 3-/5 for flexion and extension. Therapy was recommended. A daily therapy visit dated 02/25/11 noted him to be hurting. The therapist indicated he had little progress with strengthening but had progress with flexibility in extension.

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

The reviewer finds that Physical Therapy 2xWk x 3Wks is not medically necessary for this male who has had an arthroscopic partial lateral meniscectomy and abrasion arthroplasty for a lateral meniscal tear and grade III arthritis about the right knee. Postoperatively, there was physical therapy notation of poor patient compliance. Based upon the time since the surgery, his progression, and the concomitant diagnosis of arthrosis, further physical therapy is not medically necessary based on the records available for review. The reviewer used the Official Disability Guidelines Treatment in Worker's Comp, 2011 Updates, Knee Chapter in making this determination.

Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5)

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

Arthritis (Arthropathy, unspecified) (ICD9 716.9)

Medical treatment: 9 visits over 8 weeks

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)