

# US Decisions Inc.

An Independent Review Organization  
9600 Great Hills Trail, Ste 150 W  
Austin, TX 78759  
Phone: (512) 782-4560  
Fax: (207) 470-1085  
Email: manager@us-decisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Oct/12/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

12 physical therapy visits with evaluation

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

M.D., Board Certified 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**

Official Disability Guidelines-Treatment for Workers' Compensation  
Utilization review determination dated 09/08/11, 08/29/11  
Health insurance claim forms  
Operative report dated 07/13/11  
Handwritten progress report dated 08/23/11, 07/25/11  
Handwritten daily notes dated 07/28/11-08/24/11  
Office visit note dated 08/23/11, 07/20/11, 06/29/11, 05/10/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xxxx. Follow up note dated 05/10/10 indicates that the patient has some soreness on the inside of the right knee. The note states that there is nothing to stop him from doing his job or anything else he would like to do. On exam he has full motion of his knee. MRI reportedly shows a small tear of his medial meniscus. The patient was released to work full duty. The patient underwent right knee arthroscopy with partial medial meniscectomy along with chondroplasty on 07/13/11 followed by 12 patient physical therapy sessions. Office visit note dated 08/23/11 indicates that the patient has returned to work with some restrictions. The patient continues with quadriceps atrophy.

The request for additional PT was denied on 08/22/11 because the request was deemed in excess of guideline recommendations and no exceptional factors were noted. There was no evidence that the patient is to progress into the performance of a fully independent home exercise program, and that such a program could not address the patient's remaining deficits. On 09/08/11, the request was again denied, noting that there was no documentation of recent comprehensive, objective clinical findings. The therapy goals were not presented for review.

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

The patient is a 51 year-old male whose date of injury is 02/25/2010. He underwent right

knee arthroscopy with partial medical meniscectomy on 07/13/11 followed by 12 postoperative physical therapy sessions. The Official Disability Guidelines support up to 12 visits for the patient's diagnosis. The submitted records provide no clear rationale to support exceeding the ODG recommendation. There are no exceptional factors of delayed recovery documented. There are no specific, time-limited treatment goals provided. The reviewer finds there is not a medical necessity at this time for 12 physical therapy visits with evaluation and the previous adverse determinations should be upheld.

**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)