

I-Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/15/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

twelve sessions of physical therapy to the left knee

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

M.D., Board Certified Orthopedic Surgeon (Joint)

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds medical necessity is not established for the requested twelve sessions of physical therapy to the left knee.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Operative report dated 06/06/12

Office visit note Dr. dated 06/14/12

Physical therapy progress notes dated 07/30/12-09/14/12

Utilization review determination for physical therapy dated 08/15/12

Case management note dated 08/22/12

Peer review dated 08/28/12

Utilization review determination dated 09/04/12 for physical therapy dated 09/04/12

Prospective review (M2) response dated 09/26/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. The patient reports she lost her balance when a student grabbed her ankle. The patient underwent left knee arthroscopy with partial medial meniscectomy and chondroplasty on 06/06/12. Note dated 08/06/12 indicates that the patient has completed 8 sessions of physical therapy and her surgeon is requesting 12 additional sessions. It appears that the patient was authorized for 12 additional sessions. Note dated 09/14/12 indicates that the patient notes no change since last visit. Patient is tolerating treatment well.

Initial request for 12 sessions of physical therapy was non-certified on 08/15/12 noting that the patient has completed 20 sessions of physical therapy postoperatively. The requested

physical therapy exceeds the Official Disability Guidelines. The denial was upheld on appeal dated 09/26/12 noting that the Official Disability Guidelines would support 12 postoperative physical therapy visits over twelve weeks. The Official Disability Guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home exercise program. The claimant has had physical therapy sessions in line with Official Disability Guidelines. As stated by the physician advisor, at this point there is no reasonable justification per documentation submitted for further therapy beyond a home exercise program. Medical notes from the provider did not describe any clinical necessity for additional ongoing formal therapy versus an aggressive home exercise program. The claimant should be independent with an aggressive home exercise program because it is important that patients stay active and increase their activity to minimize disuse atrophy, aches and pains and to increase their endorphin levels.

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

The patient underwent left knee arthroscopy with partial medial meniscectomy and chondroplasty on 06/06/12 and has completed 20 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 12 visits for the patient's diagnosis, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. Serial notes indicate that the patient notes no change since last visit. It appears that the patient has plateaued in physical therapy. The reviewer finds medical necessity is not established for the requested twelve sessions of physical therapy to the left knee.

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)