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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/08/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: physical therapy x 12 sessions (97110, 97112, 97140)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified Pain Medicine

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. It is the opinion of the reviewer that the request for physical therapy x 12 sessions (97110, 97112, 97140) is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 02/01/13, 02/20/13
Preauthorization request undated
Initial evaluation dated 01/22/13
Plan of care dated 01/22/13
Script dated 01/14/13
Preauthorization intake form dated 02/07/13
Initial physical examination dated 02/05/13
Approval of request to change treating doctor dated 02/26/13
Handwritten follow up assessment dated 03/12/13
Physical examination dated 03/12/13
Prescription request dated 03/12/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as when he fell in a hole and twisted his right knee. The patient underwent arthroscopic meniscectomy on 10/13/09 and has undergone 2 Orthovisc injections, per initial evaluation dated 01/22/13. Initial physical examination dated 02/05/13 notes that pain is rated as 9/10. Right knee range of motion is extension 10, flexion 115, varus angle 20, valgus angle 20, internal rotation 5 and external rotation 5 degrees. Physical examination on 03/12/13 indicates that pain is unchanged at 9/10. Right knee range of motion is unchanged.

Initial request for physical therapy x 12 sessions 97110 97112 97140 was non-certified on 02/01/13 noting that per telephonic consultation with the requesting provider, the patient was sent to physical therapy only because he needed a knee replacement and they would not

cover a knee replacement until physical therapy was completed. The Official Disability Guidelines detail the recommended maximum number of 12 visits over 12 weeks for patients status post surgical intervention with meniscectomy. The documentation submitted for review details that the patient underwent meniscectomy on 10/13/09 with notes detailing the patient attended the requisite number of physical therapy sessions postoperatively. Additionally, the patient has undergone prior treatments to include 2 Orthovisc injections in 12/2011, with the patient issued a post-op knee brace and 2 additional physical therapy sessions in 11/2012. Moreover, it appears as though physical therapy is not of benefit to the patient and there was a lack of clinical documentation to indicate a clear clinical rationale for continued physical therapy outside the recommended treatment guidelines.

There was a lack of documentation to indicate that the patient has a new onset of symptoms versus continued pain. The denial was upheld on appeal dated 02/20/13 noting that ODG recommends maximum of 9 visits of physical therapy over 8 weeks for pain in the joint. Additionally, the guidelines detail the recommendation for the maximum of 12 visits over 12 weeks for patients postsurgical for meniscectomy repair. The documentation submitted for review details that the patient has attended 14 total sessions of physical therapy to date. There is a lack of documentation of physical therapy notes from the prior sessions attended to indicate a functional improvement of the patient as a result of having undergone therapy. Additionally, there was a lack of documentation detailing exceptional factors for the patient to undergo physical therapy outside the recommended treatment guidelines as opposed to a home exercise program from which the patient could derive further benefit.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xx/xx/xx. He subsequently underwent meniscectomy on 10/13/09 followed by 12 initial visits of physical therapy, 2 Orthovisc injections in December 2011 and 2 additional physical therapy visits in November 2012. The Official Disability Guidelines support up to 12 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The patient's compliance with an ongoing active home exercise program is not documented. As such, it is the opinion of the reviewer that the request for physical therapy x 12 sessions (97110, 97112, 97140) is not recommended as medically necessary.

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)