

US Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: physical therapy 3xWk x 3Wks 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

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 3xWk x 3Wks left knee is not recommended as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 05/20/13, 05/03/13

Office note dated 05/07/13, 05/06/13, 04/16/13, 04/29/13, 03/12/13, 04/03/13, 02/20/13, 02/05/13, 01/28/13, 03/26/13, 04/15/13, 03/25/13

Patient questionnaire orthopedic surgery dated 02/20/13

Operative report dated 03/07/13

Handwritten progress note dated 02/20/13

MRI left knee dated 01/30/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped on a conveyor belt and injured his left knee. The patient underwent an initial course of physical therapy. MRI of the left knee dated 01/30/13 revealed findings representing a meniscal tear; additional horizontal posterior horn medial meniscal tear with inferior surface contact; discoid lateral meniscus with myxoid degeneration but no articular extension; 3 x 3 mm full-thickness cartilage defect along the lateral trochlea with mild partial thickness patellar cartilage thinning. The patient subsequently underwent left knee arthroscopic lateral and medial meniscectomy and debridement of femoral condyle on 03/07/13. Follow up note dated 05/06/13 indicates that the patient has completed 30 cumulative visits of physical therapy. The patient reports his knee is still hurting and reports pain with flexion. He reports he is not ready to return to work due to pain and functional duties at work. Active range of motion of the left knee is 0-135 degrees. Office note dated 05/07/13 indicates that range of motion is now from 0 to approximately 115 degrees. There is no effusion, but he still has a lot of synovial thickening.

Initial request for physical therapy 3 x week x 3 weeks left knee was non-certified on 05/03/13

noting that the patient has completed 18 postoperative sessions to date. The ODG recommends up to 12 visits following meniscectomy. The patient had already exceeded the guidelines' provisions. There was no mention of compelling indications that would justify the requested additional treatments beyond the guidelines' recommendations. Although the patient was noted to have a previous left knee surgery, there was no mention of complications or residual symptoms following the initial intervention that could have compounded on his current injury. The denial was upheld on appeal dated 05/20/13 noting that additional records were not provided for review. Guidelines would recommend 12 visits of physical therapy postoperatively over 12 weeks. The claimant has undergone 18 physical therapy sessions. Records do not reflect the clinical necessity of ongoing formal therapy versus an aggressive home exercise program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent left knee arthroscopic lateral and medial meniscectomy and debridement of femoral condyle on 03/07/13 and has completed at least 18 postoperative physical therapy visits to date. 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 continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for physical therapy 3xWk x 3Wks left knee 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)