

**I-Resolutions Inc.**  
An Independent Review Organization  
3616 Far West Blvd Ste 117-501  
Austin, TX 78731  
Phone: (512) 782-4415  
Fax: (512) 233-5110  
Email: manager@i-resolutions.com

**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE NOTICE SENT TO ALL PARTIES:** Oct/30/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** additional physical therapy for the left knee, 2 to 3 times per week for 4 weeks

**A 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)

**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 additional physical therapy for the left knee, 2 to 3 times per week for 4 weeks is not recommended as medically necessary.

**PATIENT CLINICAL HISTORY [SUMMARY]:** he patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is not described. Progress note dated 09/17/14 indicates diagnoses are sprain/strain of medial collateral ligament of knee, sprain/strain of anterior cruciate ligament of knee, and contusion knee. The patient has completed 35 physical therapy visits, per this note. The patient reports she has noticed about 50-60% improvement through therapy though she continues to have pain of at least 4-5/10. On physical examination left knee range of motion is -2 to 109 degrees. Strength is rated as 4/5 flexion and extension. The patient ambulates without assistive device.

Initial request for additional physical therapy for the left knee, 2 to 3 times per week for 4 weeks was non-certified on 09/23/14 noting that the patient is status post arthroscopy with ACL reconstruction on 06/11/14. Official Disability Guidelines would support 24 postoperative physical therapy sessions after an anterior cruciate ligament repair. The records reflect the claimant has attended 35 physical therapy sessions to date. The requested physical therapy would exceed guideline recommendations. Records do not reflect the clinical necessity of ongoing formal therapy versus an aggressive home exercise program. The denial was upheld on appeal dated 10/07/14 noting that the ODG recommends a maximum of 24 visits. Exceptional factors warranting deviation from the guidelines have not been provided.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient underwent arthroscopic anterior cruciate ligament repair on 06/11/14 and has completed 35 postoperative physical therapy visits to date. the Official Disability Guidelines support up to 24 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 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 additional physical therapy for the left knee, 2 to 3 times per week for 4 weeks is not recommended as medically necessary. The prior denials are 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)