

# US Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Dec/16/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 6 additional physical therapy visits to the right knee

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., Board Certified Physical Medicine and Rehabilitation and 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 6 additional physical therapy visits to the right knee is not recommended as medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 10/25/13, 11/06/13  
Physical therapy flowsheet dated 10/23/13-11/13/13  
Daily note dated 11/15/13, 11/13/13, 10/23/13  
Physical therapy progress note dated 11/15/13  
Physical therapy initial examination dated 10/23/13  
Follow up note dated 10/16/13, 09/09/13, 11/20/13  
Visit questionnaire dated 09/09/13  
Radiographic report dated 09/09/13, 08/06/13  
MRI right knee dated 08/27/13  
Letter dated 12/03/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. The patient pushed up with the right leg and felt a pop. MRI of the right knee dated 08/27/13 revealed complex tear posterior horn medial meniscus; and chondromalacia within the patellofemoral and medial tibiofemoral compartments. Note dated 09/09/13 indicates that the patient underwent 5 sessions of physical therapy as well as a right knee injection. Follow up note dated 10/16/13 indicates that the patient has been going to therapy twice a week without any home exercise program. She has been doing a home exercise program. She reports the same pain. On physical examination EHL, anterior tib, and gastrocnemius muscles are intact to motor testing. Sensation is intact. Knee range of motion is 0-135 degrees. The knee is stable to varus and valgus testing. There is tenderness to palpation along the lateral aspect of the knee. No effusion is present. Lachman's, McMurray's and anterior/posterior drawer testing is negative. The note states that the patient's complaints do

not match the MRI findings and therefore the patient is not a surgical candidate.

Initial request for 6 additional physical therapy visits to the right knee was non-certified on 10/25/13 noting that the Official Disability Guidelines would support an expectation for an ability to perform a proper non-supervised rehabilitation regimen when an individual has received the amount of supervised rehabilitation services previously provided. The denial was upheld on appeal dated 11/06/13 noting that the patient has had 14 visits of PT. A modification of 2 visits was offered for transition to a home exercise program.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been authorized for at least 16 physical therapy visits to date. The Official Disability Guidelines support up to 9 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 6 additional physical therapy visits to the right 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)