

# 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

**DATE NOTICE SENT TO ALL PARTIES:** May/29/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 12 sessions of physical therapy, right knee

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., 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 this reviewer's opinion that the request for 12 sessions of physical therapy, right knee

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who was injured on xx/xx/xx when she slipped, injuring her right knee. The patient is noted to have undergone a prior right knee arthroscopic medial and lateral meniscectomy with removal of chondral fragments on 02/04/15. The patient was referred for postoperative physical therapy by , which began on 02/18/15. The patient reported severe pain, 9/10 in intensity per the physical therapy report. Physical exam noted limited range of motion in the right knee, with a 3 degree extension lag and flexion to 73 degrees. The patient had difficulty with weight bearing, but was trying to wean off crutches. There was 1+ effusion noted but minimal joint line tenderness was present. Mild to moderate weakness was noted at the quadriceps and hamstrings. The patient did have a moderately antalgic gait. The patient attended physical therapy through 03/27/15. Per the report, the patient had a normal gait and had pain-free range of motion. Flexion was to 127 degrees in the right knee with no evidence of an extension lag. The patient was felt to have obtained improvement with physical therapy, and was recommended to continue with the home exercise program. The patient was seen by on 04/22/15. Per this physical exam, there was no significant loss of range of motion or weakness of the right knee. The requested 12 sessions of physical therapy for the right knee was denied on 03/27/15 as there were minimal findings on physical exam to support continuing physical therapy, given the completion of physical therapy to date. The request was again denied on 04/23/15 due to the lack of any exception factors to warrant ongoing physical therapy over a home exercise program.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient is status post arthroscopic repair of the menisci, as well as removal of chondral fragments in the right knee, completed in February of 2015. The patient did attend a reasonable period of physical therapy through 03/27/15. Per the most recent evaluations by the physical therapist, there was no evidence of any exceptional factors such as loss of range of motion, motor weakness, or other provocative findings to support ongoing physical therapy outside of the amount recommended by guidelines, as compared to continuing with a home exercise program. Specifically, the patient's physical therapist indicated the patient could reasonably continue with a home

exercise program only. Due to the lack of exceptional factors present in the right knee to support ongoing physical therapy as recommended by guidelines, it is this reviewer's opinion that the request for 12 sessions of physical therapy, right knee is not medically necessary and the prior denials remain 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)