

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Set/04/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Continued physical therapy 2 x a week x 6 weeks

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Family 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 this reviewer's opinion that medical necessity for continued physical therapy 2 x a week x 6 weeks has been established and the prior denials are overturned.

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who was injured on xx/xx/xx when she slipped and fell injuring multiple areas to include the shoulder, low back, and leg. The patient did attend physical therapy in 2014 for 10 sessions. The patient is noted to have had a prior left knee arthroscopy completed in November of 2011. A repeat left knee arthroscopy with partial medial meniscectomy was completed on 03/31/15. The patient was referred for postoperative physical therapy and the patient attended 13 sessions through 06/11/15. Per this evaluation, the patient still had complaints of left knee pain at 6/10 in intensity that was exacerbated with walking or bending. The patient did demonstrate a slightly antalgic gait with a decreased stance and stride. There was still mild weakness noted in the left lower extremity at the hips, knees, and ankles. Range of motion was only slightly limited on flexion to the left knee at 120 degrees actively as compared to 125 degrees in the right knee. The patient was seen for a postoperative follow up on 07/29/15. The patient described increased pain and locking of the left knee. Physical examination still noted an antalgic gait with medial joint line tenderness and tenderness over the popliteal fossa. The 08/16/15 clinical report also noted continuing complaints of locking, popping, and giving way within the left knee. The patient's physical examination noted pain with left knee range of motion. Active range of motion was reported as limited; however, no specifics were provided. There was a continuing positive McMurray's sign. The patient was recommended to continue with physical therapy for the left knee to reduce pain and improve range of motion.

The requested physical therapy for the left knee 2 x a week for 6 weeks was denied by utilization review as the patient had completed the recommended amount of physical therapy following a meniscectomy procedure. There was also no documented comprehensive assessment of recent treatment completed to date or the patient's response to treatment.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient had 12 sessions of postoperative physical therapy following the meniscectomy procedures completed earlier in 2015. The last physical therapy assessment did note some loss of range of motion in the left knee on flexion with mild weakness. The most recent reports continued to note left knee pain including popping and giving way symptoms. The patient still had loss of range of motion with positive provocative results for a meniscal tear. The patient also had limited results with Ibuprofen with associated side effects. In this case, the patient's persistent left knee pain with objective findings for loss of range of motion and continuing meniscal symptoms as well as failure of continuing anti-inflammatories would support an additional 12 sessions of physical therapy. There are clearly exceptional factors in this case which would support continuing with physical therapy as originally prescribed. As such, it is this reviewer's opinion that medical necessity for continued physical therapy 2 x a week x 6 weeks has been established and the prior denials are overturned.

**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 KNOWLEDGBASE

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)