Medical Assessments, Inc.

4833 Thistledown Dr.
Fort Worth, TX 76137
P: 817-751-0545
F: 817-632-9684

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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Reconsideration for PT 3 x a week x 6 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Orthopedic Surgeon with over 15 years of experience

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XXXX who was injured on XXXX. The claimant underwent surgical repair of a fractured patella, followed by a right knee arthroscopy in XXXX.

XXXX: MRI of the right knee W/O contrast interpreted by **XXXX**. Impression: 1. Previous patellar fracture repair with metal artifact degrading the quality of the exam somewhat. 2. Tiny edema-like change in the medial tibial plate suggesting a subtle chondromalacia or possible a tiny contusion. 3. No internal derangement.

XXXX: Test form by **XXXX**. Diagnosis: Right lateral meniscuses tear due to old injury. Right medial meniscus tear due to old injury. Right knee primary osteoarthritis. Right knee pain.

XXXX: Knee evaluation by **XXXX**. Assessment: Right LE pain, decreased right knee ROM, decreased strength, decreased balance, difficulty walking, difficulty performing transitional movements, LEFS: 74% impairment.

XXXX: UR performed by **XXXX**: Rationale for denial: Since request exceeds ODG guidelines of 9 visits for arthritis of knee, I cannot recommend approval without peer discussion.

XXXX: UR performed by **XXXX**: Rationale for denial: The limited documentation provided does not include any CPT codes for the treatment modalities requested by the treating Physical Therapist. Additionally, it is unclear why PT is being utilized at this time given that the initial injury and surgical intervention provided for the inciting event was approximately **XXXX**. The requested PT visits are considered note medically necessary.

XXXX: Office visit by **XXXX**. Claimant was seen for reevaluation of the right lateral meniscus tear due to old injury, right medial meniscus tear due to old injury and right knee primary osteoarthritis. The claimant is not on pain meds. XXXX having an achy pain which XXXX rates a 3 on a 1-10 scale.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for physical therapy is denied.

This patient sustained a patella fracture in **XXXX**, which required surgery. The patient currently reports intermittent pain in XXXX knee rated 3/10 in severity. XXXX is not taking any medication for XXXX knee pain. The **XXXX** office note does not clearly state any functional deficit associated with XXXX knee pain.

XXXX most recent MRI of the knee (**XXXX**) demonstrates no evidence of internal derangement. XXXX has no evidence a medial or lateral meniscus tear. XXXX has a small degree of edema in the medial compartment, consistent with a possible chondromalacia versus tiny contusion in the medial tibial plateau.

The requested physical therapy is not medically necessary. The patient has minimal pain and no clear evidence of knee dysfunction, or significant pathology identified on MRI. XXXX does not require further treatment for this injury, which occurred **XXXX**.

ODG Guidelines:
ODG Physical Medicine Guidelines –
Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.
Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella:
Medical treatment: 9 visits over 8 weeks
Post-surgical (Meniscectomy): 12 visits over 12 weeks
Sprains and strains of knee and leg; Cruciate ligament of knee (ACL tear):
Medical treatment: 12 visits over 8 weeks
Post-surgical (ACL repair): 24 visits over 16 weeks
Old bucket handle tear; Derangement of meniscus; Loose body in knee; Chondromalacia of patella; Tibialis tendonitis:
Medical treatment: 9 visits over 8 weeks
Post-surgical: 12 visits over 12 weeks
Articular cartilage disorder - chondral defects:
Medical treatment: 9 visits over 8 weeks
Post-surgical (Chondroplasty, Microfracture, OATS): 12 visits over 12 weeks
Pain in joint; Effusion of joint:
9 visits over 8 weeks
Arthritis (Arthropathy, unspecified):
Medical treatment: 9 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment, arthroplasty, knee: 24 visits over 10 weeks
Abnormality of gait:
9-48 visits over 8-16 weeks (based on specific condition)
Fracture of neck of femur:
Medical treatment: 18 visits over 8 weeks
Post-surgical treatment: 24 visits over 10 weeks
Fracture of other and unspecified parts of femur:
Post-surgical: 30 visits over 12 weeks
Fracture of patella:
Medical treatment: 10 visits over 8 weeks
Post-surgical (closed): 10 visits over 8 weeks
Post-surgical treatment (ORIF): 30 visits over 12 weeks
Fracture of tibia and fibula:
Medical treatment: 12-18 visits over 8 weeks
Post-surgical treatment (ORIF): 30 visits over 12 weeks
Amputation of leg:
Post-replantation surgery: 48 visits over 26 weeks
Quadriceps tendon rupture:
Post-surgical treatment: 34 visits over 16 weeks
Patellar tendon rupture:
Post-surgical treatment: 34 visits over 16 weeks
Hamstring strain:
Medical treatment: 12 visits over 8 weeks
Post-surgical: 24 visits over 16 weeks
Work conditioning
See Work conditioning, work hardening

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ACOEM- AMERICAN 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)**