MAXIMUS Federal Services, Inc.
807 S. Jackson Road, Suite B
Pharr, TX 78577
Tel: 956-588-2900 ◆ Fax: 1-877-380-6702

DATE OF REVIEW: X/22/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Physical therapy for XX knee (X times a week for X weeks)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D., Board Certified in ortho 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)

I have determined that some of the requested is medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was involved in a work injury on XXXX, per referral note, and is post arthroscopic medial meniscectomy status of the XX knee on XXXX. A post-op examination, dated XXXX, indicates the patient complains of XX knee pain rated X/X in severity sometimes as high as X/X. XXX is doing formal physical therapy and a home exercise program. Physical examination XX tenderness with range of motion at X to X degrees. The treatment plan is for light duty status. It is noted the patient has been authorized for X visits post-operative physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

ODG Knee chapter physical therapy guidelines. The claimant has already attended X sessions of physical therapy post-operatively and ODG Knee Chapter recommends X visits post-operative for an arthroscopic meniscectomy of the knee. ODG guidelines do not support an additional X visits to physical therapy. The additional X visits would put the total number of visits at X,

which exceeds the number of post-op PT visits defined in the ODG guidelines for post-op knee arthroscopy with meniscectomy. Only X additional visits should be approved.

Therefore**,** I have determined that only X more visits is medically necessary for treatment of the patient's medical condition.

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)**