

## IRO NOTICE OF DECISION – WC

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### Notice of Independent Review Decision

**DATE OF REVIEW:**            08-03-2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical Therapy 3 x 4 Weeks for 12 sessions

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Certified by The Physical Medicine & Rehabilitation  
General Certificate in Physical Medicine & Rehabilitation

**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)

Injury Date	Claim #	Review Type	ICD-9 DSMV	Service Units	Upheld/ Overturn
		Prospective	844.9	8	Overturn
		Prospective	844.9	4	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Non-Authorization Notice 05-10-07, 06-11-07,  
Revised Notice 07-10-07  
Patient Face Sheet / Case Information  
Physical Therapy Pre-Authorization Request 05-07-07  
Consultation Report 04-27-07, 05-24-07

Initial Behavioral Medicine Consultation 05-08-07

Initial Evaluation 05-01-07

**PATIENT CLINICAL HISTORY:**

This patient sustained injury on his left knee on xx/xx/xx. X-ray of left knee revealed mild medial joint space narrowing, no evidence of fracture or joint effusion. On 04-27-07 consultation visit, the physician noted slight effusion in the superior portion of the left patella, decrease ROM and difficulty with ambulation. Impression was left knee strain and the treatment plan was for a knee brace and physical therapy.

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

In the professional opinion of the Reviewer, the patient is a candidate for four visits of Physical Therapy (three for actual Physical Therapy, with one for teaching an independent Home Exercise Program), as this would constitute a reasonable course of conservative management. The patient has x-ray evidence of joint space narrowing and given his age and mechanism of injury to deny physical therapy completely minimizes the patient a chance for improvement.

In addition, the patient's anxiety and depression over not being able to work can be classified as reactive.

Physician physical examination dated 4-27-07 noted a slight effusion in the superior portion of the left patella. The patient also had difficulty with stooping and kneeling.

Physician physical examination dated 05-24-07 demonstrated resolution of effusion. The patient continued to wear a knee brace and had pain improvement on Motrin.

The patient was diagnosed with left knee strain 844.9.

**Literature Cited:**

ODG Guidelines for ICD diagnoses 844 states that if there is no improvement after 2-3 weeks the protocol may be modified.

A review of the medical literature including Arthritis Rheumatology and recommendations from the Academy of Sports Medicine and American Academy of Orthopedic Surgery support conservative treatment including physical therapy in early case of knee sprain.

Lumetra's Physician Reviewer has no known conflicts of interest in this case, pursuant to the Insurance Code Article 21.58A (Chapter 4201 effective April 1, 2007), Labor Code § 413.032, and § 12.203 of this title.

**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)

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