



Specialty Independent Review Organization

Notice of Independent Review Decision

NAME:

DATE OF REVIEW: 7/18/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include physical therapy codes consisting of 97110, 97140, 97116, 97035 and 97112.

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

The reviewing physician is a Doctor of Chiropractic who has an additional board certification in rehabilitation and has greater than 10 years of experience in this field.

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)

The reviewer agrees with the previous adverse determination regarding all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the requesting doctor (Dr.), a consulting doctor (Dr.) and from the URA.

The records from Dr. consisted of a single report of 4/19/07.

The records from the URA consisted of the following: 6/8/07 initial visit charge sheet, 6/8/07 report by Dr. 7/11/07 letter Confirmation of receipt of IRO request

and associated paperwork, 6/25/07 denial (reviewer not named), 6/28/07 denial (reviewer not named) and 6/25/07 appeal of denial from Dr..

The records from Dr. consisted of the following (in addition to any previously mentioned records): 3/30/07 report (initial and 'revised') and 6/8/07 left knee MRI.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee was injured while working. He reports an injury when he twisted his knee in a client's yard. He was treated with active therapeutics and medicinal management. However, daily treatment notes were not available from any party to determine the exact treatments and the patient's responses to said treatments. The MRI noted minor joint effusion and a cyst near the ACL.

There are two forms of the note by Dr.. One note includes basic information without any ROM or strength findings; however, the 'revised' note indicates ROM and strength findings. Both notes are indicated to go to.

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

According to the ODG, Sprains and strains of the knee (cruciate, lateral or medial collateral ligament) are noted to require 12 visits of PT over an 8 week period. The submitted notes do not document ROM improvements via the exercise until an apparently revised report is submitted. This note indicates that the patient improved by 40% with respect to knee flexion ROM and is normal as far as knee extension is concerned. The examination in June notes that the patient still has reduced patellar reflex on the left and a reduced dermatomal sensation in the L3 dermatome. Dr. opines that this is due to swelling; however, the MRI indicates only minor swelling in the joint. The patient has not improved greatly over the previous course of rehabilitation with Dr. His strength has not improved past a 4+/5. The radiological studies indicate a knee sprain/strain which does not require further in office protocols at this time as per the provided documentation.

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)**