

**IRO NOTICE OF DECISION – WC**

**Page 1**

Notice of Independent Review Decision

**DATE OF REVIEW:** 06-21-07

**IRO CASE #:**

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

Physical Therapy (Post Injection) 3X2 weeks. (6 sessions)  
CPT: 97110, 97124, 97112

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

Doctorate of Physical Therapy

**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 Number | Review Type | ICD-9 DSMV | HCPCS/<br>NDC | Upheld/Overturned |
|-------------|--------------|-------------|------------|---------------|-------------------|
|             |              | Prospective | 844.9      | 97032         |                   |
|             |              | Prospective | 844.9      | 97110         | Upheld            |
|             |              | Prospective | 844.9      | 97124         | Upheld            |
|             |              | Prospective | 844.9      | 97112         | Upheld            |

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Letter/Summary dated 06-14-07  
Determinations dated 05-15-07 and 05-24-07  
Notices of Disputed Issue(s) dated 04-04-06, 12-06-06  
Emergency Room visit of 02-27-06  
MRI of 03-13-06, 03-10-06, 08-11-06, 04-12-07  
Evaluations dated 03-22-06, 04-05-06, 04-11-06, 04-26-06, 05-22-06, 05-30-06, 06-21-06, 07-17-06, 07-19-06, 08-02-06, 08-28-06, 08-30-06, 10-09-06, 10-30-06, 11-06-06, 11-22-06, 12-21-06, 01-04-07, 01-26-07, 02-09-07, 02-23-07, 03-09-07, 03-12-07, 03-23-07, 03-30-07, 04-09-07, 04-16-07, 05-11-07  
Daily Notes Reports dated 01-10-07, 01-12-07, 02-01-07, 02-21-07, 03-05-07, 03-12-07, 03-20-07, 03-23-07, 04-02-07, 04-09-07, 04-20-07, 04-27-07, 05-09-07, 05-17-07, 05-21-07, 05-30-07  
Electro-Diagnostic Studies dated 06-13-06, 04-30-07  
Procedure Notes dated 06-27-06, 06/29/06, 10-03-06, 10-05-06, 04-27-07  
Laboratory report 10-30-06  
Cervical Myelogram/CT of 05-24-07  
Physical Therapy Evaluation/Notes from 03-30-06 – 04-25-06

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was initially diagnosed with cervical, right shoulder/knee sprain/strain after a box fell off a shelf, hitting the claimant's head knocking the claimant down. Treatment has included physical therapy, injections (cervical, knee), and pain medications.

Current diagnosis: knee/leg sprain/strain

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

Physical therapy is not indicated due to the chronic nature of the knee pain and exhaustive conservative treatment of this pain since original injury. Consultations on 4/5/06 and 5/22/06 indicated no improvement in right knee pain with physical therapy or conservative management. The claimant was also discharged from a physical therapy services at a Medical Center on 4/25/06 secondary to lack of improvement in pain. The physical therapy discharge summary indicates that a home exercise program was given to the claimant at that time and the claimant was instructed to continue with exercises at home.

Based on clinical expertise, there is no indication for the necessity of physical therapy following a steroid injection of the knee. The Reviewer was unable to find evidence in peer-reviewed physical therapy literature to support a statement that "it is medically necessary to finish these 6 sessions of rehab as soon as

possible right after each injection to enhance the effect of the procedure by reducing muscle spasm, swelling, and improve the mobility of the involved joints”.

**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)**