

Notice of Independent Review Decision  
**REVISED**  
Failed to put date on 1<sup>st</sup> page of decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 04/13/08

**IRO CASE #:**

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

Additional physical therapy services three times weekly for two weeks.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified Psychiatrist and Specialist in Physical Medicine and Rehabilitation, Diplomate of McKenzie Institute International with Special Training in Mechanical Diagnosis and Treatment, with advanced training in the McKenzie System of spine care and extremity care with approximately 35 years experience in management of Physical Medicine and Rehabilitation problems, both acute sports injuries, work-related injuries, and more severe disability

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. TDI case assignment
2. Letters of denial 01/07/08, 01/29/08 & 03/21/08, and criteria for denial (ODG)
3. Physical therapy documentation 07/09/07 – 12/19/07
4. H&P and follow up 07/03/07 – 02/13/08

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

1. I have carefully reviewed all the information including the medical physician records from the physician who first saw the patient on 07/03/07 for an injury that occurred on xx/xx/xx. The problem was right knee pain. The patient had tremendous pain initially when she twisted her knee and heard a loud pop. This did occur at work. The MRI scan showed degenerative changes, but the compensable injury apparently was a right medial meniscus tear, which was acute. This was a xx-year-old female, apparently slim and trim. She was referred for physical therapy, initially with a right acute medial meniscus tear. Follow up visits reviewed an acute medial meniscus tear with intractable pain and a right knee effusion. Those diagnoses were continued through 10/30/07 when additional right foot strain/diagonal sprain was added and a right plantar fasciitis. These were felt to be secondary to overuse because of the knee pain. At that time she was receiving, I believe, Vicodin and Motrin. She had had Mobic. Mention is also made that an orthopedic consultation was cancelled in August 2007. The patient did continue to work with restrictions. On 11/27/07 she was again seen by this physician; and, again it was noted that she had decreased range of motion of flexion and extension of the right knee. The degree of motion loss was not indicated in his records, but she went from maybe 4 degrees to 135 degrees, according to the physical therapy notes in July or August. On 11/27/07 the diagnosis was again right medial meniscus tear, but a lateral meniscus tear, an osteochondral defect,

chondromalacia patella, loose body, and then the right foot sprain, diagonal sprain, and plantar fasciitis had been added.

2. She had apparently seen an orthopedic surgeon, who scheduled her for Hyalgan injections in a series of five and also right knee arthroscopy. I do not have his records, so I do not know why she was scheduled for two different procedures, both apparently directed at treating the same problem. She was also referred for a pain management referral. On 12/18/07 the patient again was noted to have a right medial meniscus tear. Again the right lateral meniscus had been added, plus the other diagnoses mentioned before. She was given Vicodin ES #120 tablets to take one four times a day for pain. She was still awaiting approval of the pain management referral.
3. On 01/16/08 her treating doctor mentioned that her case was being denied. She had not been back to see the orthopedic surgeon, and she had not had the pain management evaluation. He again noticed decreased range of motion but did not include any numbers. She had a positive Apley's test, Smiley's test, and patellar grind. She had a joint effusion. She apparently walked with a limp. She had continued working.
4. Finally on 02/13/08 she saw the TD and he mentioned she had seen a Designated Doctor. There is no name, and the Designated Doctor indicated she needed surgery, which I believe would mean arthroscopy. She was again noted to have decreased flexion and extension of the right knee, right knee effusion, and positive Apley's and Smiley's test and patellar grind. He indicated then that the effusion was a large joint effusion, and she walked with a limp. Again, he included the additional diagnoses.
5. I also reviewed the physical therapy notes, which indicated that the patient was treated about nine sessions consisting of modalities, range of motion exercises, and she was taught a home exercise program. There is no indication in any of the records that the patient had followed the home exercise program.
6. There was a re-evaluation by the physical therapist on 12/19/07, indicating the patient had attended ten of ten sessions. She was working in a fast-paced job as a and was working about a 40-hour week. She required Vicodin to perform her job and rated her pain about 2/10 and without medications about 10/10. The note indicated that she was scheduled for a neurologic consult on 01/22/08. Her range of motion measurements were, it appears, from 4 degrees to 135 degrees, which was quite good, although maybe not as good as the left knee. Measurements were made of her leg, but there was no comparison with the other side. Her strength was 5/5 for flexion and extension, and there was no instability of the knee. The recommendation was for three visits per week over two weeks to again do range of motion modalities and train the patient in a home exercise program. There was no mention in the physical therapy note as to what the home exercise program was that was given, I believe, in October, nor if the patient had followed any of the recommendations.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

I would recommend that additional therapy not be upheld or approved at this time. Part of the process of physical therapy is to train the patient to treat themselves at home. Generally that can be done in about five or six visits of physical therapy with rare exception. Almost all of the modalities provided in a physical therapy office can be done by a patient at home. The patient did have a torn medial meniscus. The orthopedist saw her and scheduled both Hyalgan injections and arthroscopy. The patient does not need additional physical therapy at this time.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
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**INDEPENDENT REVIEW INCORPORATED**

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- 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 national accepted medical literature (provide a description).
  - Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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