

Notice of Independent Review Decision

DATE OF REVIEW: 10/7/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy Left Knee 2x3

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 7/1/2006 and Pain Management since 9/9/2006. This reviewer currently resides in TX.

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)

Physical Therapy Left Knee 2x3 Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Case assignment dated 9/17/2009
2. Independent review organization by Author unknown, dated 8/27/2009
3. Letter dated 8/27/2009
4. Review organization dated 7/16/2009
5. Letter by Author unknown, dated 6/9/2009
6. Letter by MD,, dated 3/13/2009
7. Clinical note by Author unknown, dated unknown
8. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male who was injured when a tractor scoop fell on him . A request for post injection therapy 3 times per week for 2 weeks was submitted on 5/5/09 to include therapeutic exercise, manual therapy and neuromuscular re-education. Most recent office notes on 9/14/09 note continued pain to left knee that is constant. MRI documented from 7/10/09 reveals effusion, bone bruise at medial femoral chondral defect at the medial condyle and partial tear of MCL and possible posterior horn meniscal tear. Exam shows severe tenderness on the medial/lateral hamstring tendon, range of motion of flexion is 0-90 and extension 0-0; effusion is absent, crepitus is present and compression test is positive. Recommended treatment has included topical modalities, PT for 9 sessions to knee; left knee injection on 5/13/09 did not help, FCE done on 7/2/09.

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

Recommendation is that the previous denial be upheld regarding physical therapy to the left knee 2 times per week for 3 weeks. According to the available medical records, the injured employee has not had significant improvement to date with 9 sessions of PT or with the knee injection. Furthermore, the injured employee continues to have significant complaints of functional deficit and continued significant physical exam findings of severe tenderness along with effusion, crepitus and positive compression test to go along with positive MRI findings. According to ODG, standard non-operative physical therapy treatment of knee injuries is recommended at 9 sessions of PT. ODG does recommend as medically necessary 1-2 sessions of post injection physical therapy. However, given the injured employee's lack of response to prior treatments, i.e. failure of physical therapy trial, including 9 sessions of PT and injection and continued significant functional complaints and findings on examination on 9/14/09, it is unlikely that continued physical therapy at 3 times per week for 2 weeks would be of significant benefit based on ODG recommendations. Thus, the recommendation is to uphold the denial.

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)