



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org



NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Non-network (WC)
MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 08/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3xWk x 4Wks left (97002, 97035, 97110, 97112, 97140, and 97530)

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

Texas State Licensed MD Board Certified Occupational Medicine physician

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 07/20/2010
2. Notice of assignment to URA 07/20/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 07/20/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 07/14/2010
6. Coventry letter 06/17/2010, 07/09/2010, carrier submission 07/21/2010, review 07/05/2010, note 06/29/2010, 06/14/2010, progress notes 06/07, 09, & 11/2010, note 05/20/2010, progress notes 05/20, 26, & 29/2010, radiology 05/18/2010, note 05/13/2010, TDI forms 06/29/2010, 06/14/2010, 05/13/2010
7. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:

This is a man who suffered injury to his left knee due to a fall incident on xx/xx/xx. On examination, he was noted to have mild pain, ecchymosis and swelling over the joint with some restriction of range of motion; there was no evidence of ligament or meniscal tear; his X-rays were also reported normal. The patient was diagnosed with traumatic prepatellar bursitis and hematoma. He was prescribed physical therapy for the relief of the symptoms. Subsequently, the patient underwent MRI of the left knee for further evaluation, which reported "High-grade partial mid-substance PCL (posterior cruciate ligament) strain". The claimant was diagnosed with partial tear of posterior cruciate ligament and was decided to be treated without surgical intervention. On his last follow-up, the patient reported improvement in his condition except for giving out of his knee several times in the last couple of weeks; he denied any pain in his knee. He was recommended PCL brace and additional



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physical therapy along with purchase of a home exercise bicycle for strengthening of his left leg muscles and prevention of instability of the knee.

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

Per ODG guidelines, 09 PT visits over 8 weeks are recommended for Pain in joint; Effusion of joint (ICD9 719.0; 719.4). As per ODG Guidelines: 12 PT visits over 08 weeks are recommended as medical treatment of sprains and strains of knee; cruciate ligaments of knee (ACL tear) (ICD9 844; 844.2). Often non-operative treatment is recommended for acute isolated PCL tears. This involves control of initial pain and inflammation followed by muscle strengthening exercises. Recovery of quadriceps strength is necessary to compensate for posterior tibial subluxation and to facilitate return to pre-injury activity levels.

The claimant has suffered an injury to his left knee as a result of a fall accident. His history, clinical findings, and imaging studies are consistent with PCL tear. He has completed 8 PT sessions with partial relief in the symptoms. As the patient is decided to be treated conservatively, his satisfactory recovery is highly dependent on the ability to adhere to a strict rehabilitation program. Thus, a full course of continuous supervised physical therapy, focused on muscle strengthening (quadriceps and hamstrings), is indicated in this patient to help in developing sufficient stability of the knee and to be able to perform his activities of daily life normally; therefore, the insurer's denial is overturned.

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
- AHCP- 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)