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Notice of Independent Review Decision

DATE OF REVIEW: 4/23/10

IRO CASE #:

Description of the Service or Services In Dispute
Physical therapy 3x wk x 4 wks

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

Physician Board Certified in Physical Medicine and Rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld	(Agree)
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

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

Adverse determination letters, 4/7/10, 4/3/10, 4/1/10, 3/26/10
MRI right knee 6/23/09
Clinical notes, xxxxxxxx 6/09-3/10
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who fell down stairs in xx/xxxx. She was seen in the ER with pain in the right wrist and in both knees and was diagnosed with contusion, cartilage defect, and internal derangement of the right knee. She was later treated with an initial four sessions of physical therapy, and in July and August had 6 more physical therapy sessions. She was maintained on modified duty status at work. She was further diagnosed with chondromalacia patella. She had three more sessions in October. She completed physical therapy and was using Biofreeze, service analgesics and Naprosyn, her medications were refilled and she was returned to her regular duty. She apparently had a minor exacerbation with a fall at work in 1-26-10. She was seen on 2-3-10, and reported an increase in knee pain due to weather changes. She reportedly was doing a home exercise program. Four more sessions of physical therapy were performed in February and March 2010.

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

I agree with the decision to deny the proposed physical therapy. I agree with the previous reviewer, that faithful and consistent home exercises would constitute the best therapy. The patient has received a sufficient number of physical therapy visits for her non-surgical condition.

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)