

Prime 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-9015
Email: manager@prime400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Aquatic Therapy and Passives for the Right Knee 3x/wk for 4 Weeks

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

MD, Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG-TWC, Knee
Letter from attorney dated 03/10/11, 2/28/11
Authorization, 3/10/11
Physical therapy treatment records, 3/15/11, 2/15/11
MRI right knee dated 02/10/11
CT of right knee dated 02/10/11
Physician 3/15/11, 2/15/11, 3/22/11, 3/21/11
Provider, undated

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a XX year-old male who is reported to have sustained work related injuries on XX/XX/XXXX. It is reported the claimant sustained a fall and continued to have chronic right knee pain. Records indicate the claimant was taken to surgery on 08/12/10 and underwent a right chondroplasty. The record includes MRI of the right knee dated 02/10/11 with reported diagnosis of reflex sympathetic dystrophy. The claimant is reported to be status post repair of avulsed cartilage of the medial patella. It is reported there is a new area of signal abnormality involving the medial patellar facet roughly parallel to articular surface in costochondral junction. There is no evidence of displacement of cartilage at this time. The anterior and posterior cruciate ligaments are noted to be intact. The lateral collateral and medial collateral ligaments are intact. There is abnormal signal change in patellar tendon diffusely consistent with intrasubstance tear/myxoid change. The record contains CT of right knee dated 02/10/11, which reported a moth-eaten trabecular pattern consistent with disuse. It is reported there is a periarticular pattern of signal abnormality suggesting reflex sympathetic dystrophy. It was recommended the claimant undergo a three-phase bone scan. The record contains a utilization review determination dated 02/24/11. This report indicates that the claimant allegedly has not had physical therapy post-operatively, which is unexplained as there were no surgeon or follow-up records for review. The reviewer notes the performance

of passive modalities in postoperative period is highly unusual. There is no documentation regarding the claimant's inability to perform a home exercise program. The reviewer subsequently non-certified the request. This request was appealed and reviewed. on 03/17/11. Dr. notes the claimant slipped and fell while exiting work truck. He slammed his right knee on door and developed pain in his knee cap. It is reported he did not receive any postoperative physical therapy and was subsequently recommended for 12 sessions of aquatic therapy. He notes CT suggests possible presence of reflex sympathetic dystrophy of the limb. It is noted that the ODG guidelines recommend incorporation of aquatic therapy as optional form of exercise therapy if land based therapy fails. Records indicate the claimant was participating in physical therapy program and range of motion was improving. Dr. subsequently upheld the previous determination.

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

The medical necessity for Aquatic Therapy and Passives for the Right Knee 3x/wk for 4 Weeks is not supported by the submitted clinical information. The available clinical record indicates the claimant struck his knee on XX/XX/XXXX. He did not make any significant improvement with conservative treatment and was ultimately taken to surgery where he underwent an apparent chondroplasty and chondral repair. The record did not include this operative report. Postoperatively the claimant was seen in follow-up with Dr. and has been receiving chiropractic treatment from D.C. The records report the claimant has not had any postoperative physical therapy. The validity of this statement needs to be assessed. Typical postoperative recovery for knee arthroscopy is a course of active physical therapy. There is no clinical data, which would suggest the claimant is incapable of active therapy, nor is there data to suggest the claimant is unable to weight bear on affected extremity. As such, the medical necessity for passive modalities and aquatic therapy is not supported by current evidence based guidelines, and the previous utilization review determinations are upheld. The reviewer finds no medical necessity for Aquatic Therapy and Passives for the Right Knee 3x/wk for 4 Weeks.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

- ACOEM-AMERICA 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)