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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 4/13/11

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of physical therapy (97110), Manual therapy (97140) and electrical stimulation (G0283) to the lumbar spine, left hip and knee times 12 sessions.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of physical therapy (97110), Manual therapy (97140) and electrical stimulation (G0283) to the lumbar spine, left hip and knee times 12 sessions

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

### **PATIENT CLINICAL HISTORY (SUMMARY):**

This claimant has a date of birth of xx/xx/xx. She was working when she slipped on liquid on the floor falling to her left knee. The date of injury was xx/xx/xx. She complained of left knee, left hip, left thigh, left wrist and low back pain. She is 4'11" and 134 pounds. She has a history of hypertension, depression, anxiety and headaches. She did have therapy for her knee pain. She also received injections to the knee secondary to the iliotibial band syndrome. She was treated with therapy for her pain. She was placed at MMI in December of 2010. She did return to work in November of 2010. After returning to work, 11 months after the fall, she reported increased pain. She was shown a home exercise program. There is no documentation of her following through with her HEP.

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

The ODG does recommend therapy for a strain syndrome of the back, knee or hip. The ODG indicates that there should be documentation of progress with therapy in order to continue therapy. The ODG indicates therapy should focus on active exercises as opposed to passive care and that the therapy should decrease in frequency (fade) over several weeks with emphasis on an HEP and transitioning the patient to a HEP. The ODG recommends 10 visits of therapy for a strain.

ODG 2010 TWC Knee p. 535 Physical medicine treatment is recommended. As with any treatment, if there is no improvement after 2-3 weeks, the protocol may be modified or re-evaluated. Acute muscle strains often benefit from daily treatment over a short period, whereas chronic injuries are usually addressed less frequently over an extended period. The physical therapy provider must document patient's progress so MD or DC can modify the care plan, if needed.

In a strain of the knee or leg, 12 visits are recommended over 8 weeks. If there is not the above documentation as to progress, or reason for continued therapy, then additional therapy over a year past the injury is not indicated.

ODG 2010 TWC Low Back p. 683-684 There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. Evidence supports active therapy and not passive modalities. The most effective strategy may be to provide an individually designed exercise program in a supervised format such as home exercises with regular therapist follow up. Patient should be encouraged to exercise regularly and include stretching and strengthening exercises. Allow for fading frequency of treatment plus active self-directed home PT. For a lumbar strain 10 visits of PT are recommended.

This claimant has had the appropriate number of visits for the injury suffered and should be able to perform an HEP independently. The claimant was placed at MMI and additional supervised therapy will not change the clinical outcome in this case. Based upon the above factors, the requested treatment does not fall within treatment guidelines. Therefore, it is not medically necessary at this time.

**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)