

SENT VIA EMAIL OR FAX ON  
Jul/06/2011

## **P-IRO Inc.**

An Independent Review Organization  
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### **NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:**

Jul/05/2011

**IRO CASE #:**

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

12 PT visits for the right knee

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

Board Certified Chiropractic Examiner

**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**

#### **PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. On this date the patient fell on her knees in the parking lot at work. MRI of the right knee dated 04/02/08 revealed evidence of tearing involving the medial collateral ligament likely extensive partial tear or possibly complete tear or near complete tear; myxoid change in the menisci without definite evidence of meniscal tear. Note dated 06/11/08 indicates that previous injection produced increased pain. Lower EMG/NCV dated 10/02/08 revealed an indication of L3 and L4 radiculopathy. Note dated 12/19/08 indicates that the patient had right knee arthroscopy on 12/08/08. The patient subsequently completed approximately 15 sessions of postoperative physical therapy. Note dated 08/31/09 indicates that the patient underwent lumbar fusion on 03/02/09 followed by a course of postoperative physical therapy. Peer review dated 11/29/10 indicates that it is not medically probable that the current complaints are related to the xx/xx/xx work event that was a probable right knee strain. There is no additional formal therapy, work hardening or pain management reasonably required as related to the xx/xx/xx work event. Evaluation dated 05/11/11 indicates that the patient reports a constant burning pain in the right knee. On physical examination motor strength is rated as 4/5 with flexion and extension of the right knee. Apley's compression/distraction test is positive on the right for increase in medial knee pain. McMurray's testing was positive on the right for an increase in medial knee pain. Varus/valgus stress tests were positive on the right. Right knee range of motion is 100/150 flexion, -5/0 extension.

Initial request for 12 PT visits for the right knee was non-certified on 05/20/11 noting guidelines recommend 12 PT visits for an injury of this nature. No documentation was submitted regarding the patient's physical therapy history. The denial was upheld on appeal dated 06/08/11 noting that the patient completed at least 11 postoperative physical therapy visits as well as a chronic pain management program in late 2010 which included a physical therapy component. There is no comprehensive assessment of the patient's response to previously completed PT.

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

Based on the clinical information provided, the request for 12 PT visits for the right knee is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent right knee arthroscopy in December 2008; however, the operative report is not submitted for review to establish the nature and extent of surgical intervention. The patient completed approximately 15 postoperative physical therapy sessions; however, the patient's objective, functional response to these sessions is not documented. There are no specific, time-limited treatment goals provided to support additional PT at this time. Peer review dated 11/29/10 reports that there is no additional formal therapy, work hardening or pain management reasonably required as related to the xx/xx/xx work event. The patient should be well-versed in and encouraged to perform an independent, self-directed home exercise program.

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

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**