

SENT VIA EMAIL OR FAX ON
Jun/26/2012

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jun/26/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

8 PT sessions

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

PM&R and Pain Medicine

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 medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO dated 06/07/12
Utilization review determination dated 05/10/12
Utilization review determination dated 05/25/12
Clinical records Dr. dated 09/02/11-04/16/12
Clinic note Dr. dated 02/10/12
EMG/NCV lower extremity dated 03/08/12
MRI lumbar spine dated 04/10/12
Physical therapy records
Physical therapy progress reports

PATIENT CLINICAL HISTORY [SUMMARY]

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. On this date the claimant is reported to have fallen at work site sustaining injuries to left knee, left heel, right ankle and left elbow. The claimant subsequently was seen by Dr. on 09/02/11. At this time he reported only his left knee remains symptomatic. He has been undergoing therapy and pain on medial aspect of knee has improved considerably; however, he has persistent lateral sided pain. Records indicate the claimant is 5'3" tall and 312 lbs. Range of motion is 0-130. He has positive posterolateral pain with maximum flexion. He has positive pain with lateral McMurray's. He has positive lateral joint line tenderness. He has patellofemoral crepitus. Patella mobility is limited to approximately 1.5 / 4 medially and laterally. He has no ligamentous instability. Radiographs show mild tricompartmental degenerative changes. The claimant was subsequently referred for MRI of the knee to the left intraarticular pathology. On 11/07/11 the claimant was seen in follow-up. He is reported to be receiving 5th left knee Supartz injection. He is reported to have persistent symptomatic degenerative osteoarthritis of the knee. Her physical examination is grossly unchanged. The claimant was seen in follow-up on 12/02/11. He is noted to be status post a course of hyaluronic acid injections and extensive physical therapy. He is noted to have sustained an intervening aggravation to his knee. Physical examination remains unchanged. There is recommendation for additional physical therapy. The claimant was referred to Dr. for neurologic evaluation. The claimant is noted to have constant dull pain in lateral aspect of left knee to left mid-thigh graded as 2-3/10. Physical examination was grossly unremarkable. There is suggestion of meralgia paresthetica. The claimant was referred for electrodiagnostic studies. This study performed on 03/08/12 showed possibility of early peripheral neuropathy. There is possibility of left meralgia paresthetica which cannot be completely ruled out. The claimant was noted to be participating in home exercise program. MRI of lumbar spine was performed on 04/10/12. This study notes small medium sized central and right paracentral disc protrusion at L4-5 level with associated moderate bilateral degenerative facet disease or mild hypertrophy of ligamentum flavum, mild central spinal stenosis and minimal right foraminal stenosis. There is tiny left paracentral disc protrusion along with mild diffuse disc bulge, associated mild bilateral degenerative facet changes with mild flattening of the left lateral recess. Records indicate the claimant was subsequently referred for 8 additional sessions of physical therapy. The provided physical therapy records indicate the claimant previously received 20 sessions of physical therapy between 07/07/11 and 10/27/11.

The initial request was reviewed on 05/10/12. The reviewer notes the guidelines recommend 10 visits over 8 weeks for lumbar strain and 12 visits over 8 weeks for knee sprain/strain. He notes 04/16/12 note is unclear as to exactly where therapy is to take place. He notes it is unclear if the prescribed physical therapy for lumbar spine, knee, ankle or foot.

A subsequent appeal request was submitted and reviewed on 05/25/12. At this time the reviewer Non-certified the request noting the clinical documentation lacked evidence to support current request. He notes as clinical documentation indicates the claimant has utilized physical therapy sessions for current complaints of pain and decreased function to left lower extremity. Documentation and progress notes of physical therapy were not submitted for review. He notes the request does not specify if this physical therapy is for patient's knee or low back. He notes there is no indication when the claimant last participated in supervised therapeutic exercise program.

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

The request for 8 sessions of physical therapy is not supported by the submitted clinical records and the prior utilization review determination is upheld. The submitted clinical records indicate the claimant sustained multiple strain injuries as result of a work place event. The claimant is noted to be morbidly obese and have chronic knee pain. He has been treated with oral medications, physical therapy, corticosteroid injections, and viscosupplementation. The records indicate the claimant has previously completed over 20 sessions of physical therapy for treatment regarding his knee. The request for 8 sessions

exceeds current evidence based guidelines regarding the claimant's knee. As there is no specific body part identified, it is presumed these sessions were recommended for chronic pain associated with knee. In absence of more specific treatment plan, the request is not supported under Official Disability Guidelines.

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)