



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

May 24, 2012

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 5/23/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Twelve additional physical therapy visits for the right knee.

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

Texas State Licensed DO Board Certified Physical Medicine & Rehabilitation physician

REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Assignment to 5/8/2012,
2. Notice of assignment to URA 5/7/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 5/8/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 5/8/2012
6. Insurance prospective review response 5/9/2012, ODG physical medicine guidelines not dated, Insurance letter 5/1/2012, work status report 4/28/2012, physical therapy evaluation 4/27/2012, preauthorization 4/26/2012, medical information 4/26/2012, insurance information 4/2/2012, preauthorization 3/28/2012, change assessment 3/28/2012, medicals, work status report 3/9/2012, preauthorization 1/3/2012, work status report 12/29/2011, medicals.

PATIENT CLINICAL HISTORY:

The patient is a female who sustained an occupational slip-and-fall injury dated xx/xx/xx. When the patient slipped and fell, she landed on her hands and knees. The patient underwent



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subsequent right knee diagnostic x-rays, which are reportedly negative. A right knee MRI scan was performed approximately 1 month post injury due to persistent right knee pain demonstrating right ACL and MCL strains. The patient received approximately 18 sessions of outpatient physical therapy treatment with minimal improvement.

The patient underwent a second-opinion orthopedic evaluation, on March 22, 2012. Reportedly, additional diagnostic x-rays of the right knee demonstrate a patellar dislocation, and therefore the physician ordered additional right knee physical therapy treatment.

Review of the initial submitted physical therapy evaluation of the right knee dated March 28, 2012, demonstrates minimal right knee effusion and moderate medial joint line tenderness to palpation. Gait is mildly antalgic on the right with decreased gait cadence. The patient does not utilize any ambulatory assistive device. Active right knee range of motion demonstrates minimal restrictions, and right lower extremity strength is mildly impaired. Left lower extremity strength is normal. Right lower extremity strength is mildly impaired at 4-/5 with right knee extension 3+/5. Anterior/posterior drawer tests are negative. Medial/lateral stress testing is also negative.

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

The requested additional 12 physical therapy treatment sessions for the right knee remain non-authorized, because this request fails to satisfy *Official Disability Guidelines*, as the patient has received sufficient prior 18 physical therapy treatment sessions, which would be adequate for management of this particular problem. Furthermore, the submitted March 28, 2012, physical therapy evaluation of the right knee indicates only a minimal degree of residual right knee functional impairment that would not medically justify the requested additional 12 physical therapy treatment sessions; therefore, the insurer's denial is upheld.

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 KNOWLEDGBASE
- 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



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- 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)**