



Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 02/04/13

IRO CASE #:

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

Texas-licensed M.D., board certified in Orthopedic Surgery

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy for the right knee – 12 visits.

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)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
			<i>Prosp.</i>						<i>Upheld</i>

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- TDI case assignment.
- Letters of denial 10/24/12 and 11/21/12, including criteria used in the denial.
- Hospital emergency department visits 12/16/11 and 01/01/12.
- IME and FAE 06/18/12.
- Medical history and review of systems 02/07/12.
- MR – right knee w/o contrast 01/17/12.
- Evaluations and follow up (physician assistant) 01/05, 01/12 & 01/27/2012.
- Preauthorization request for physical therapy/exercise program 10/18/12.
- Correspondence to injured worker from employer (undated).
- Work status reports 01/12, 01/27 & 02/10/2012.

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant is a male and an xx who suffered an injury to his right knee on xx/xx/xx when he fell into a hole. It would appear that he has been treated for pain in the right knee with non-steroidal anti-inflammatory medications, activity modification, and crutches on a periodic basis. A request for twelve sessions of physical therapy was submitted and denied. It was submitted for reconsideration and denied.

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

The current status of this requested physical therapy is unclear. The clinical notes are dated in January of 2012, more than one year before this evaluation date. There is a Functional Assessment Evaluation in June of 2012; however, there are no current medical records submitted to justify this request for physical therapy for the right knee. The prior denials of this request were appropriate and should be 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 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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)