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IRO Cert # XX

DATE OF REVIEW: FEBRUARY 6, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Medical necessity of the proposed Physical Therapy to the left knee 3 X week for 4 weeks
(97001 X1, 97110 X12, 97112 X12, 97124 X 12)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is Board Certified in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
XX Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a XX-year-old XX who was injured on XXX, in a mechanism not denoted. The claimant was diagnosed with status post left total knee arthroplasty and Baker's cyst. Evaluation on XXXX, noted the claimant was having continued pain in the left knee. X-rays of the left knee revealed the previous total knee arthroplasty was within perfect position and alignment with ACL screw noted of the femur, tibia and the patella sat flat over the femoral component. There was bogginess and swelling of the popliteal bursa with mild calf pain on physical examination. There was full range of motion of the left knee, which felt stable with interior to posterior stress and medial to lateral stress. It was noted that the claimant underwent a left knee replacement in XXXX.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE: The request was previously non-certified by XXXX on XXXX, as there was no evidence of necessity for continued treatment to include further physical therapy. No additional documentation was submitted to support the request. The previous non-certification is supported. According to the guidelines, the use of physical therapy for left knee pain is recommended nine visits over eight weeks. The current request exceeds the recommended guidelines. It was noted on physical examination that the claimant has full range of motion with no evidence of instability, and there is no medical reason given as to why the claimant would benefit from further physical therapy XXXX after the date of reported injury. The request for physical therapy for the left knee (97001, 97110 X12, 97112 X 12, 97124 X 12) is not medically necessary.

Official Disability Guidelines ODG Treatment Integrated Treatment/Disability Duration Knee (Acute and

Chronic) (updated 12/28/17) ODG guidelines
Physical medicine treatment
Recommended as indicated below. As with any treatment, if there is no improvement after 2-3 weeks, the protocol may be modified or re-evaluated. See also specific modalities linked below. (Philadelphia, 2001)
ODG Physical Medicine Guidelines –
Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface. Pain in joint: 9 visits over 8 weeks

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
☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

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

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

XX 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)