

# Parker Healthcare Management Organization, Inc.

3719 N. Beltline Rd Irving, TX 75038

972.906.0603 972.906.0615 (fax)

IRO Cert#XX

**DATE OF REVIEW:** OCTOBER 8, 2018

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

Medical necessity of proposed Physical Therapy (97110, 97112, 97124) XX Knee 3 X 4 weeks

## **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 specializes 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:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a XXXX who was injured on XXXX, in a mechanism that was not denoted. The claimant was diagnosed with XX knee pain, medial XX tear of XX knee. An MRI of the XX knee without contrast was performed on XXXX, which revealed the following; internal XX involving the XX XX, XX involving the medial joint compartment XX XX, XX XX change, XX the XX, prominent XX knee joint effusion, and a XX XX. An evaluation on XXXX, revealed that the claimant was unable to return to work due to XX knee pain. The XX knee revealed no tenderness or swelling, and negative XX'XX test.

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

The claimant has continued pain in the XX knee. According to the guidelines, physical therapy is generally recommended to help increase functionality. There are no updated medical records provided for review to include clinical exam findings of the XX knee to support the medical necessity of requested additional physical therapy. There was also no medical reason provided as to why the claimant could not be transitioned into active participation in a home exercise program to continue to work on strengthening and increase functionality of the XX knee. Therefore, medical necessity for the physical therapy, XX knee, 3 x 4 weeks is not established.

Official Disability Guidelines Treatment Integrated Treatment/Disability Duration Knee (Acute and Chronic) (updated 07/06/18) ODG guidelines Physical medicine treatment Recommended as indicated below. As with any treatment, if there is no improvement after XX 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 XX visits per week to XX or less), plus active self-directed home PT. Tear of XX of knee: Medical treatment: XX visits over XXweeks Post-surgical (Meniscectomy): XX visits over XX weeks

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES