



# INDEPENDENT REVIEW INCORPORATED

## Notice of Independent Review Decision

**DATE OF REVIEW:** 04/03/09

**IRO CASE #:**

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

- 97110 continued PT exercises, right knee 3xwk x3weeks; combination of 4 total units per session
- 97010 hot or cold packs therapy, right knee
- 97014 electric stimulation therapy, right knee
- 97035 ultrasound therapy, right knee
- 97140 manual therapy, right knee
- 97124 massage therapy, right knee
- 97530 therapeutic activities, right knee
- 97116 gait training therapy, right knee

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D. licensed in the State of Texas for over 30 years, board certified in ABS Specialty of Physical Medicine and Rehabilitation

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or 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>
836.0	97110 97010 97014 97035 97140 97124 97530 97116		Prosp	6					Upheld
836.0	97110 97010 97014 97035 97140 97124 97530 97116		Prosp.	3					Overturn

**INFORMATION PROVIDED FOR REVIEW:**

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

**1908 Spring Hollow Path  
Round Rock, TX 78681  
Phone: 512.218.1114  
Fax: 512.287-4024**

According to the medical documentation provided, this injured employee is a female who sustained the onset of pain, limited ability to do daily activities, and catching in the right knee following a work-related injury on . The original injury failed to respond to non-operative treatment including anti-inflammatory medication and physical therapy. An MRI scan performed on the right knee indicated a tear of the posterior root of the medial meniscus with extrusion of the body, grade 1 medial collateral ligament sprain pattern, and small joint effusion.

The patient underwent right knee arthroscopic partial medial meniscectomy with the diagnosis of tear of medial cartilage or meniscus of the knee with date of procedure 01/28/09. The patient post surgery had received nine post surgical physical medicine/physical therapy treatment sessions.

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

The injured employee had undergone arthroscopic surgery to the involved knee. The ODG recommend postsurgical guidelines for this condition as twelve treatment sessions. The original denial noted a dispute of nine additional treatment sessions of the identified CPT code physical medicine services identified above. The initial dispute noted that while some of the treatment sessions might fall within the ODG criteria, an adverse preauthorization response was provided.

Using the Official Disability Guidelines for post surgical meniscectomy, it is indicated that twelve visits over twelve weeks is medically reasonable and necessary per evidence-based treatment guidelines. It does appear that with the ODG indicating that twelve treatments post surgically would be medically reasonable and necessary, an additional three sessions would fall within the medically reasonable and necessary ODG criteria to the nine that the injured employee had already received.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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-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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description).