



Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 07/13/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional post-operative physical therapy, right knee 3 X 4 (97113 X 2 and 97110 X 2)

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery

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>
717.9	97110		Prosp.	2					Overturn
717.9	97113		Peosp.	2					Overturn

INFORMATION PROVIDED FOR REVIEW:

**P. O. Box 215
 Round Rock, TX 78680
 (1908 Spring Hollow Path, 78681)
 Phone: 512.218.1114
 Fax: 512.287-4024**

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is an obese male who injured his knee at work when going down into a kneeling position to both knees. He failed conservative management and underwent arthroscopic treatment. He was found to have a partial tear of the anterior cruciate ligament and posterior cruciate ligament, severe chondromalacia of the patellofemoral joint, and medial and lateral meniscal tears. A debridement and chondroplasty were performed as well as dermal augmentation of the ACL and PCL. Postoperatively the patient is progressing very slowly and has received twelve physical therapy visits. On the date of the last visit he had range of motion from 0 degrees to 110 degrees, quadriceps weakness, and a limp. Continued physical therapy has been denied by the insurance company.

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

The decision to deny the therapy should be overturned, as this patient is an exception to the standard twelve visits after meniscectomy. The patient also had partial ACL and PCL injuries and is obese and falls outside the norms of a standard patient who has a simple arthroscopic meniscectomy. Although the patient did not have ACL/PCL reconstruction, dermal augmentation most likely is not adequate to stabilize the ACL and PCL, and that, combined with the patient's weight, would most likely lead to the requirement for more skilled physical therapy, in particular aquatic therapy. I believe that the request for twelve more visits of therapy is medically reasonable and necessary based on this patient's clinical scenario.

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.- REFERENCED
- 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.)