

# **INDEPENDENT REVIEWERS OF TEXAS, INC.**

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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 09/21/10

**IRO CASE NO.:**

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

Item in dispute: APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS

Dates Of Service From 8/23/2010 To 9/20/2010

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

Texas Board Certified Orthopedic Surgeon

### **REVIEW OUTCOME**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Overturned

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Office visit notes Dr., 07/20/10 to 07/29/10
2. Therapy referral form, 07/20/10
3. Initial evaluation PT dated 07/29/10
4. Utilization review determination dated 08/25/10
5. Notification of determination dated 08/26/10
6. Letter regarding request for reconsideration dated 08/26/10
7. Utilization review determination dated 08/30/10
8. Notification of determination dated 08/30/10
10. **Official Disability Guidelines**

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a female whose date of injury is xx/xx/xx.

The earliest record submitted for review was an office visit note dated 07/20/10. The employee's chief complaint was left knee pain. The employee was status post left knee arthroscopy and the wounds looked good. The diagnosis was tear, medial meniscus, knee, current. The employee would be started in physical therapy.

Physical therapy initial evaluation dated 07/29/10 indicated that the employee was injured at work on xx/xx/xx when she was squatting to pick up some product off the floor. She stated she hit the right knee and the pain persisted until it gradually became worse. The employee was status post right knee meniscectomy performed on 07/12/10. The employee's chief complaint was of right knee pain. Objective clinical findings noted no gross abnormalities, minimal to no swelling of the knee, and minimal to no atrophy of the lower extremity. The employee had some difficulty with ambulation including stairs due to continued pain and

weakness. There was tenderness to palpation throughout the anterior knee, portals and the posterior knee. Range of motion of the right knee was 0-85 degrees. There was an extensor lag of 5 degrees. The employee was recommended to be seen two to three times per week for four weeks with reassessment in thirty days.

A previous request for twelve visits of physical therapy over four weeks to the right knee with CPT codes 97110, 97140, 97116, 97113, 97535, 97014, 97035, 97010 and 97124 was non-certified noting that the **Official Disability Guidelines** did not support the use of passive modalities, and it was not clear why gait training and aquatic therapy had been recommended. The denial was upheld on appeal dated 08/30/10 noting that **Official Disability Guidelines** support up to twelve visits of physical therapy for the employee's diagnosis utilizing CPT codes 97110, 97116, 97113, 97124 and 97140; however, codes 97535, 97014 and 97010 were not allowable per **Official Disability Guidelines**.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

Based on the clinical information provided, the request for APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS Dates Of Service From 8/23/2010 To 9/20/2010 is recommended as medically necessary utilizing only active modalities. The employee underwent left knee meniscectomy on 07/12/10. Physical therapy initial evaluation dated 07/29/10 reported that the employee had some difficulty with ambulation including stairs due to continued pain and weakness. There was tenderness to palpation throughout the anterior

knee, portals and the posterior knee. Range of motion of the right knee was 0-85 degrees. There was an extensor lag of 5 degrees. The **Official Disability Guidelines** support up to twelve visits of physical therapy for the employee's diagnosis. Therefore, the request for APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS Dates Of Service From 8/23/2010 To 9/20/2010 is indicated as medically necessary.

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

1. **Official Disability Guidelines** Treatment Integrated Treatment/Disability Duration Guidelines, Knee and Leg Chapter, Online Version

#### **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](#).

**Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella** (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5):

Medical treatment: 9 visits over 8 weeks

Post-surgical (Meniscectomy): 12 visits over 12 weeks