INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision
CORRECTED REPORT
Omitted IRO Case # and Name

REVIEWER'S REPORT

DATE OF REVIEW: 09/03/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Therapeutic procedures, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering internal derangement of the knee

REVIEW OUTCOME:
Upon independent review, I find that the previous adverse determination or determinations should be :

___X__Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
836.0	*97110*		*Prosp.*	*12*			*Xx/xx/xx*	*xxxxx*	*Upheld*
836.0	*97113*		*Prosp.*	*12*			*Xx/xx/xx*	*xxxxx*	*Upheld*
836.0	*97116*		*Prosp.*	*12*			*Xx/xx/xx*	*xxxxx*	*Upheld*
836.0	*97140*		*Prosp.*	*12*			*Xx/xx/xx*	*xxxxx*	*Upheld*
836.0	*97530*		*Prosp.*	*12*			*Xx/xx/xx*	*xxxxx*	*Upheld*

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
The patient suffered an injury to her left knee on xx/xx/xx. The mechanism of injury is not described in the clinical record provided. She suffered knee symptoms. The specific symptoms also have not been described. Ultimately on 05/25/11, she underwent an arthroscopic surgical procedure with partial medial meniscectomy involving the posterior horn of the medial meniscus. Postoperatively she has been provided with a physical therapy regimen including at least twelve sessions of physical therapy including therapeutic maneuvers to maintain flexibility, improve strength, and improve functional capacity. She has had persistence of mild antalgic gait, though she is not utilizing any ambulatory assistive devices. She has received appropriate physical therapy. The current request is for an additional twelve sessions of physical therapy. The request was considered and denied, reconsidered and denied.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
The patient has been provided with an appropriate regimen of postoperative physical therapy after an arthroscopic partial medial meniscectomy. She can be transitioned to a home program of range of motion exercises and strengthening. The prior denial of the request for additional physical therapy was appropriate and should be upheld.

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.
__X__ Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
_____Mercy Center Consensus Conference Guidelines.
_____Milliman Care Guidelines.
__X __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.)