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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional PT 2 x a week for 4 weeks to include CPT codes 97110 x 4, 97140 x 3, 97035 x 3, G0283

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

MD, Board Certified in Physical Medicine & Rehabilitation

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Employer's first report of injury or illness dated xx/xx/xx
Handwritten progress notes dated 05/13/11-08/04/11
Physical therapy initial examination and daily notes dated 05/16/11-06/09/11
MRI left knee without contrast dated 05/25/11
Office / outpatient visit notes dated 06/03/11 and 07/12/11
Comprehensive Solutions, Prospective / concurrent review determination additional physical therapy 2 times a week x 4 weeks dated 06/23/11
Comprehensive Solutions, Prospective / concurrent review determination appeal additional physical therapy 2 times a week x 4 weeks dated 06/30/11
Peer review Dr. dated 07/07/11
Official Disability Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx.. The patient slipped and fell due to ice and water. Physical therapy initial evaluation notes right knee AROM is 0-130 degrees. Strength is rated as 4+/5 in flexion and 4/5 Extension. McMurray's is negative. The patient underwent 12 sessions of physical therapy. MRI of the right knee dated 05/25/11 revealed moderate joint effusion with a plica in the suprapatellar region; Baker's cyst of moderate size; patellofemoral disease, small patellar spurs and grade II chondromalacia patella; grade II increased signal within the posterior horn of the medial meniscus which does not extend to the articular surface. Daily note dated 06/09/11 indicates that the patient complains of continued right knee pain and soreness. Peer review dated 07/07/11 indicates that the compensable injury is a right knee contusion/strain. Reasonable treatment plan is simple maintenance follow up. Further active treatment is not required. The provider's request for additional physical therapy was non-certified on 06/23/11 noting that the request is well in

excess of ODG recommendations. The denial was upheld on appeal on 06/30/11 noting that ODG supports up to 9 sessions of physical therapy over 8 weeks. The clinician has not described the clinical necessity for ongoing physical therapy at this point vs. an aggressive home exercise program.

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

This patient sustained a right knee contusion/strain and has completed 12 sessions of physical therapy to date. The Official Disability Guidelines support up to 9 sessions for the patient's diagnosis. There is no clear rationale provided to support exceeding this recommendation.

There are no exceptional factors of delayed recovery documented. The patient is noted to have full range of motion of the knee. Additionally, ODG does not support the utilization of modalities 97035 and G0283 for this patient's diagnosis. The patient has completed sufficient formal therapy and ODG would recommend continuing to improve strength and range of motion with an independent, self-directed home exercise program, rather than formal physical therapy. The reviewer finds that medical necessity does not exist for Additional PT 2 x a week for 4 weeks to include CPT codes 97110 x 4, 97140 x 3, 97035 x 3, G0283.

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

- ACOEM-AMERICA 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 JUDGEMENT, 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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)