

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: April 20, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy to include Electrical stimulation (CPT code 97032), Therapeutic Exercises (CPT code 97110), Aquatic Therapy/Exercises (CPT code 97113), and Manual Therapy (CPT code 97140).

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

Diplomate, American Board of Orthopaedic Surgery

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

Medical records from the Additional Physician include:

- , xx/xx/xx
- , 05/22/08, 05/29/08, 06/09/08, 06/24/08, 07/15/08, 08/12/08, 09/23/08, 10/09/08, 11/11/08
- MRI & Imaging, 08/04/08, 08/05/08, 08/16/08
- , 09/03/08
- , 10/14/08
- M.D., 10/15/08
- , 11/13/08
- , M.D., 01/08/09, 01/09/09

Medical records from the URA include:

- Official Disability Guidelines, 2008
- Employer's First Report of Injury or Illness, xx/xx/xx
- , 05/04/08, 06/23/08,06/26/08, 07/01/08, 07/03/08, 07/08/08, 07/10/08,07/15/08, 07/16/08, 07/29/08, 07/31/08, 08/04/08, 08/05/08, 08/11/08, 08/13/08, 09/22/08, 09/24/08, 10/01/08, 10/02/08, 10/06/08, 10/07/08, 10/08/08, 12/08/08, 12/22/08, 12/23/08, 12/24/08, 12/29/08, 12/30/08, 12/31/08, 01/05/09, 01/06/09, 01/07/09, 01/12/09, 01/13/09, 01/14/09, 02/03/09, 02/04/09, 02/05/09, 02/09/09, 02/10/09, 02/11/09, 02/17/09, 02/18/09, 02/19/09, 02/23/09, 02/24/09, 02/25/09, 03/02/09, 03/03/09, 03/10/09, 04/02/09
- , 05/21/08
- , L.L.P., 05/22/08, 05/29/08, 06/09/08, 06/24/08, 07/15/08, 08/12/08, 09/23/08, 10/09/08, 11/11/08
- P.T., 06/04/08
- MRI & Imaging, 06/16/08, 08/04/08, 08/05/08, 01/29/09
- , M.D., 06/20/08, 07/22/08, 09/11/08, 12/19/08, 01/22/09, 01/26/09, 03/02/09, 03/17/09
- M.D., 09/03/08, 11/12/08
- 09/17/08, 10/08/08, 10/22/08, 11/10/08, 11/14/08, 11/21/08, 12/17/08, 12/31/08, 01/21/09, 02/18/09, 03/18/09
- , 10/14/08
- , M.D., P.A., 10/15/08
- , 11/13/08
- , 02/04/09
- , D.C., 03/02/09
- , M.D., 03/17/09
- Ms. , 04/01/09
- Texas Department of Insurance, 04/0/09

Medical records from the Requestor/Provider include:

- , 04/09/09, 09/03/08, 09/17/08, 10/08/08, 10/22/08, 11/10/08, 11/14/08,11/21/08, 12/17/08, 12/31/08, 01/21/09, 02/18/09, 03/18/09
- , L.L.P., 06/09/08, 06/24/08, 07/15/08

- MRI & Imaging, 08/05/08
- , 11/13/08
- Texas Department of Insurance, 04/07/09

Medical records from the Additional Physician include:

- , 05/21/08
- L.L.P., 05/22/08, 05/29/08, 06/09/08, 06/24/08, 07/15/08, 08/12/08, 09/23/08, 10/09/08, 11/11/08
- MRI & Imaging, 08/04/08, 08/05/08, 08/16/08
- , 09/03/08
- , 10/14/08
- , M.D., P.A., 10/15/08
- , 11/13/08
- , M.D., 01/08/09

PATIENT CLINICAL HISTORY:

I have had the opportunity to review medical records on this patient. The records indicate a date the injury of xx/xx/xx. The dispute in this case involves physical therapy, electrical stimulation, aquatic therapy, therapeutic exercises, and manual therapy.

The records indicate that the patient fell down a flight of stairs on xx/xx/xx. The patient was evaluated in the emergency room. X-rays were negative.

The patient was evaluated by , M.D., on May 22, 2008. Anti-inflammatory medications were prescribed. Physical therapy was also prescribed.

Multiple diagnostic studies were then performed. A lumbar MRI was negative for trauma. A cervical MRI was also negative for trauma. An MRI of the knee disclosed degeneration within the medial meniscus with a partial intrasubstance medial meniscus tear.

M.D. performed a required medical examination, and opined that the patient had sustained a partial tear of the anterior cruciate ligament and a medial meniscus tear.

Surgery was subsequently recommended, and on November 13, 2008 the patient underwent a partial medial and lateral meniscectomies and synovectomy. The anterior cruciate ligament was found to be intact.

Following the surgery, physical therapy was prescribed.

The patient returned to , M.D. on November 14, 2008. The percutaneous pump was removed at that time.

By December 17, 2008, it was noted that the patient had not started physical therapy. Celebrex and Ultram were prescribed.

Subsequently, physical therapy was performed. A total of 44 visits of physical therapy ensued.

Because of continued complaints of back pain a chest CT was performed, which was essentially normal.

, M.D. performed a peer review on February 4, 2009. The peer reviewer opined that treatment had been prolonged to that point. It was his point that a somatization disorder may have been developing. Dr. opined that the patient did not require any further physical therapy, and that prescription medication should be weaned. Nonetheless, further physical therapy ensued.

The patient returned to Dr. on March 18, 2009. She continued to complain of pain in her knee; however, Dr. noted that she had good range of motion and only weakness of the quadriceps. There was diffuse tenderness without effusion or edema. There was no evidence of instability. He recommended a repeat MRI of the right knee, as well as an MRI of the left knee.

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

It is my opinion that further physical therapy is outside of the ODG Guidelines and is not medically reasonable or necessary. The denial in this case appears to be appropriate. The patient underwent surgery in November of 2008 and has had a very large amount of physical therapy in the postoperative period, which has exceeded ODG for a medial and lateral meniscus tear.

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