

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
12001 NORTH CENTRAL EXPRESSWAY
SUITE 800
DALLAS, TEXAS 75243
(214) 750-6110
FAX (214) 750-5825

Notice of Independent Review Decision

DATE OF REVIEW: August 24, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy, 3 x a week for 4 weeks, to include CPT codes #97035(ultrasound), G0283 (E-stim), 97010 (Heat/cold therapy), 97116 (Gait Training), 97530 (Therapeutic activities), 97110 (Therapeutic exercises), and 97113 (Aqua therapy with therapeutic exercises).

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 Carrier include:

- Surgery Group and 03/24/09, 04/23/09, 04/23/09, 05/15/09, 05/29/09, 06/04/09, 06/10/09, 06/11/09, 06/15/09, 06/17/09, 06/19/09, 06/22/09, 06/29/09, 06/30/09, 07/01/09, 07/13/09

- , 05/06/09, 05/19/09
- , 05/06/09
- Status Report, 05/15/09, 05/29/09, 06/30/09, 07/28/09

Medical records from the URA include:

- Official Disability Guidelines, 2008
- X X Services, Inc., 03/20/09
- Group and 06/30/09, 07/13/09
- , 07/13/09, 07/20/09, 08/10/09
- , 08/12/09

Medical records from the Requestor/Provider include:

- Group and , 11/14/08, 11/25/08, 01/02/09, 02/06/09, 02/20/09, 03/06/09, 03/24/09, 04/23/09, 05/21/09, 05/29/09, 06/04/09, 06/10/09, 06/11/09, 06/15/09, 06/17/09, 06/19/09, 06/22/09, 06/24/09, 06/26/09, 06/29/09, 06/30/09, 07/01/09, 07/13/09, 08/05/09
- , 05/06/09
- , 05/07/09

PATIENT CLINICAL HISTORY:

I have had the opportunity to review medical records on this patient. The records indicate a date of injury of xx/xx/xx, with a reported injury to the right knee. The patient fell, sustaining a chest wall injury, as well as an injury to his right knee.

An MRI scan was performed, disclosing tears of the medial and lateral meniscus. Surgery was recommended.

On May 19, 2009, the patient underwent arthroscopic right knee debridement of degenerative medial and lateral meniscal tears with chondroplasty and limited synovectomy.

Physical therapy was prescribed postoperatively. A total of twelve physical therapy visits were counted in the records. Twelve further visits of therapy were prescribed and were denied by the carrier.

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

It is my opinion that the denial in this case was appropriate. The ODG clearly supports the need for twelve visits over twelve weeks following arthroscopic partial medial meniscectomies. Additionally, there is a request for aquatic therapy, which according to ODG can be considered as an alternative but not an addition to land-based therapy. Therefore, it is my opinion that the request for additional physical therapy three times a week for four weeks is beyond ODG, and therefore, is not medically necessary.

Therefore, the denial for physical therapy, 3 x a week for 4 weeks, to include CPT codes #97035 (ultrasound), G0283 (E-stim), 97010 (Heat/cold therapy), 97116 (Gait Training), 97530 (Therapeutic activities), 97110 (Therapeutic exercises), and 97113 (Aqua therapy with therapeutic exercises) is upheld.

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)**