

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

DATE OF REVIEW: May 31, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Office visits 11-29-10 and 01-21-11. CPT Codes: 99213 and 99080.

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

FAMILY PRACTICE
PRACTICE OF OCCUPATIONAL MEDICINE

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:

- M.D., 10/31/08
- D.O., 03/25/11
- Clinic, 12/10/10, 02/07/11, 03/30/11

Medical records from the URA include:

- Official Disability Guidelines, 2008

Medical records from the Provider include:

- Clinic, 10/15/08
- Report of Medical Evaluation, 03/06/09, 10/22/09
- M.D., 03/06/09
- M.D., 03/23/09
- M.D., 10/20/09, 02/18/10, 06/09/10, 11/29/10, 01/10/11, 01/21/11, 02/21/11, 02/22/11, 05/05/11
- Work Status Report, 01/21/11, 11/29/10
- Hospital, 02/15/11
- TDI, 03/25/11, 05/03/11

PATIENT CLINICAL HISTORY:

There is an MRI of the left knee from October 15, 2008, which was two and a half years ago. This revealed joint effusion and osteoarthritic degenerative changes with a subchondral cyst in the proximal tibia. There was a tear of both horns of the medial

meniscus. There was a tear of the anterior horn of the lateral meniscus. There was proximal patellar tendinosis. This was read by M.D.

There was a peer review performed by M.D., physiatrist, on October 31, 2008. It was Dr.'s opinion that all of the diagnostic findings were related to degenerative changes and that the compensable diagnosis would include a left knee strain. Dr. felt that a course of physical therapy and rehabilitation were reasonable and necessary.

I have a designated doctor evaluation by M.D. The working diagnosis was medial meniscus tear, lateral meniscus tear, and lower leg osteoarthritis. The date of this consultation is March 6, 2009. It was determined that maximum medical improvement would not occur until June 6, 2009. In Dr.'s review of medical records, the mechanism of injury is described as "She was walking down the hall opening all the doors on the north side of the building and instead of turning to the right side, she quickly turned to the left side. She heard a pop and had immediate burning of her knee and to the left side of her body a sharp pain. She immediately sat down and felt the swelling and burning of her knee." Dr. reviewed the MRI as previously described. Dr. reviewed an orthopedic surgical consultation with D.O., from October 22, 2008. The assessment was meniscal tear and superimposed degenerative joint disease. Dr. felt that she might be an arthroscopic candidate. Reportedly, there was a dispute as to whether or not this was part of a compensable injury or the result of chronic degenerative changes. The patient was seen to be neurologically intact at the time of the impairment rating. The evaluating physician, Dr., did feel there was reasonable causality between the mechanism of injury described of a torsional injury to the knee and the observed meniscal pathology seen. Arthroscopic surgery was felt to be reasonable and necessary.

There is an orthopedic surgical consultation from March 23, 2009. The patient was seen to have 125 degrees of flexion with full extension, both actively and passively, in the involved left knee. The Apley grind test was positive. There was effusion seen. There was medial and lateral joint line tenderness seen. Sensation was considered normal. An MRI was reviewed. It is noted that the patient was taking Ibuprofen as necessary for pain. The assessment was lateral meniscal and medial meniscal tears. It was felt that arthroscopic surgery for the observed pathology was indicated.

In a follow-up visit from June 9, 2010, the patient was seen to be doing well. The recommendation was to follow up on December 8, 2010.

I have a designated doctor evaluation from October 22, 2009. It was felt the patient had achieved maximum medical improvement at that time and had a 4% whole person impairment rating as a result of her injuries. She was seen at the time of the evaluation to have full range of motion, with well-healed surgical scars. It is noted the patient had completed her postoperative physical therapy and had returned to work as of April 17, 2010, and that no additional medical treatment was indicated at that time. The diagnosis was tibialis tendinitis, meniscal tear, sprain of the knee, and lower leg injury. The patient's 4% whole person impairment was based upon a 10% impairment of the lower extremity, based upon Table 64, under specific disorders of the knee for meniscectomy, medial and/or lateral, which was converted to a 4% whole person impairment rating.

It is noted the patient had a new onset of pain on November 29, 2010. The physical examination on November 29, 2010, revealed no swelling, tenderness to deep palpation, and normal range of motion.

The patient was released to work in an unrestricted capacity by M.D., as of January 21, 2011. It is noted the patient's previous surgical procedure occurred on April 6, 2009.

In a follow-up visit from February 18, 2011, it is noted the patient was doing well postoperatively, and that she had significant functional improvement in her knee following surgery. It is noted the patient was not taking any medications.

There is a note by Dr. on February 21, 2011, stating that the follow-up visits on November 29, 2010 and January 21, 2011, were a reasonable and necessary part of her care. This has been contested in a peer review by M.D., who stated that these were not necessary.

I have a review from D.O., on March 25, 2011. This was a comprehensive review of medical records to that point. The patient's clinical history was reviewed. It is noted the patient underwent a left knee medial and lateral meniscectomy, partial; debridement; chondroplasty; and injection on April 6, 2009. Dr. was asked if ongoing prescription medications, physical therapy, and diagnostic tests were reasonable and necessary for the compensable injury. Dr. stated to the fact that the patient did not appear to be undergoing treatment. The patient had a good result from her arthroscopy and that her function returned to baseline. The patient had normal range of motion. The patient was not taking any medications. Dr. corroborated that a routine follow up at that point, as adequate healing appeared to have occurred with optimal functional recovery, was not reasonable or necessary; although, certainly covered on an as needed basis for acute exacerbations. Dr. felt that scheduled follow-up visits were neither reasonable nor necessary, as the patient was not requiring any medications. Dr. goes on to corroborate that on the visit of January 21, 2011, the patient had no pain. As such, the necessity for ongoing pain management would not seem to be corroborated. Dr. felt that her ongoing symptoms were likely the result of chronic degenerative changes, and over-the-counter anti-inflammatory agents were certainly reasonable.

In a letter of May 5, 2011, Dr. states that ongoing follow-up visits are reasonable and necessary and that the ODG Guidelines allow up to three to four follow-up visits per year for chronic pain related to this injury. Although, for an uncomplicated meniscal tear, this is well beyond what the Medical Disability Guides state would be reasonable and necessary care.

I have no further documentation.

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

I would have to corroborate that there does not appear to be any necessity for ongoing follow-up visits at this point. Following the patient's determination of maximum medical improvement on October 22, 2009, she appears to have had an optimal outcome and all pathology related to the compensable injury appears to have been resolved. The patient has had an optimal clinical improvement. Although, Dr. is quite correct that ongoing pain management is reasonable and necessary for occupational injuries. There does not appear to be any pain management being undertaken at this

point. The patient was not taking any medications except over-the-counter medications on an as needed basis. The patient had full range of motion. On January 21, 2011, the patient reported no pain on follow-up visit. As such, there does not appear to be any ongoing treatment occurring. Therefore, its medical necessity is not corroborated. At this point, based upon the lack of symptomatology and evidence of chronic degenerative changes, any exacerbations would likely be the result of degenerative changes, not acutely and directly related to the mechanism of injury. Therefore, I uphold the previous determination of non-necessity.

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 (MDG)