

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

DATE OF REVIEW: September 22, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy two times a week for six weeks for the Right Knee. CPT Codes: 97110, 97112, 97140, 97530 and 97039.

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

AMERICAN BOARD OF PHYSICAL MEDICINE AND 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

Medical records from the URA/Carrier include:

- Official Disability Guidelines, 2008
- Imaging, 05/04/11
- M.D., 05/16/11, 08/22/11
- Physical Therapy, 07/06/11, 07/07/11, 07/12/11, 07/14/11, 07/19/11, 07/21/11, 07/26/11, 07/28/11, 08/02/11, 08/04/11, 08/09/11, 08/11/11, 08/16/11, 08/19/11, 08/25/11
- Letter of Medical Necessity, 08/11/11
- 08/17/11
- 08/24/11, 09/01/11

Medical records from the Provider include:

- Physical Therapy, 07/06/11, 07/07/11, 07/12/11, 07/14/11, 07/19/11, 07/21/11, 07/26/11, 07/28/11, 08/02/11, 08/04/11, 08/09/11, 08/11/11, 08/16/11, 08/17/11, 08/25/11, 08/30/11, 09/01/11

PATIENT CLINICAL HISTORY:

The patient is a male who is status post lateral patellar dislocation while employed. The patient underwent a right knee patellofemoral ligament reconstruction, arthroscopy and loose body removal on July 5, 2011. The patient has had 17 physical therapy visits ranging from July 7, 2011 through September 6, 2011. The current debate is relative to additional physical therapy visits which have been denied.

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

The ODG criteria for physical therapy in the above setting supports nine visits over eight weeks. The patient should have been transitioned into a home exercise program. The patient has had nearly twice the amount of recommended supervised rehabilitation with likely maximal plateau in improvement currently achieved.

Consequently, it would be that additional physical therapy is unreasonable (supported by 2011 ODG criteria).

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)