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Notice of Independent Review Decision

DATE OF REVIEW: January 24, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Twelve Physical Therapy Visits between 12-06-11 and 02-04-12. CPT Code: 97110.

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

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

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)

PATIENT CLINICAL HISTORY:

To Whom It May Concern:

I had the opportunity to review medical records on this patient. The records indicate a date of injury of xx/xx/xx. There was a current request for 12 visits of physical therapy. The initial medical record is a physical therapy report indicating primary diagnosis of complex regional pain syndrome, Type II, and arthrofibrosis. The physical therapy notes indicate pain complaints and decreased range of motion.

physical therapist, wrote a letter indicating that the patient had received 34 visits of physical therapy without any functional improvement. Aquatic physical therapy was recommended by the therapist,.

An independent medical examination dated xxxxx, sheds further light on the case. The patient was a female who was injured on xx/xx/xx, while doing work for a company called. She fell directly on the knee and broke her nose. She also injured her knee and developed an osteochondral lesion with loose bodies. On xxxx, there was an arthroscopy performed for removal of the loose bodies, as well as a chondroplasty. There was a complex regional pain syndrome diagnosed following the surgery. M.D., noted that the patient used crutches and put no weight on her left leg. She was taking Norco, Tramadol, Neurontin, Xanax, Valium, and Lexapro at that time. She had been treating with Dr., and a trial of spinal cord stimulator was suggested. Dr. noted diffuse atrophy, but no trophic changes in the skin or nails nor, temperature or color asymmetries. Dr. opined that the patient's treatment was reasonable and necessary and that a trial of spinal cord stimulator was reasonable.

The case management notes indicate that the patient did undergo a spinal cord stimulator implant on March 10, 2010.

D.O., opined that further physical therapy was not indicated, based upon the ODG Guidelines, in a diagnosis of muscle ligament disease not otherwise specified.

There was an appeal letter written by the physical therapist.

On December 9, 2011, the xxxx visits were non-certified by M.D., citing the ODG Guidelines.

Additionally, there are office notes reviewed from M.D. There is a note dated August 25, 2011. He indicates that the patient had a longstanding history of left knee pain and reflex sympathetic dystrophy. He discussed the possibility of total joint replacement. X-rays disclosed minimal arthritic deformity. He indicates that the patient had a tendency toward infections and injections were, therefore, not considered. Dr. again saw the patient on October 6, 2011. He indicates continued pain behaviors and pain complaints with even the lightest touch. However, she was wearing a knee sleeve and a knee brace. He noted a 31 cm stasis ulcer without drainage. He recommended a trial of therapy, and prescribed aquatic therapy at that time.

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

The denial of the physical therapy request was reasonable and appropriate. The patient has multiple pain behaviors that are concerning. The ODG Guidelines do not support the need for further physical therapy for either a knee injury or reflex sympathetic dystrophy. It has been many years since her injury. She should be well versed at this time on physical therapy and home exercises, given the multiple physical therapy visits she has undergone. Further physical therapy is unlikely to change her condition. Additionally, the extreme hypersensitivity to any light touch is inconsistent with her use of braces. Therefore, there is a question as to the veracity of her hypersensitivity. The aquatic therapy prescribed is not consistent with the ODG Guidelines.

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**

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- ☐ **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)**