



## IMED, INC.

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### NOTICE OF INDEPENDENT REVIEW

**NAME OF EMPLOYEE:**  
**IRO TRACKING NUMBER:** M2-06-1771-01  
**NAME OF REQUESTOR:** Cotton Merritt, D.C.  
**NAME OF CARRIER:** South Plains School Workers' Compensation  
**DATE OF REPORT:** 08/07/06  
**IRO CERTIFICATE NUMBER:** 5320

#### TRANSMITTED VIA FAX:

IMED, Inc. has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO).

In accordance with the requirement for TDI to randomly assign cases to IROs, TDI has assigned your case to IMED, Inc. for an independent review. The peer reviewer selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the peer reviewer reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal.

The independent review was performed by a matched peer with the treating physician. This case was reviewed by a chiropractic physician reviewer in the area of Chiropractic Medicine and is currently listed on the DWC approved doctor list.

I am the Secretary and General Counsel of IMED, Inc., and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and the provider, the injured employee, injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization. I further certify that no conflicts of interest of any nature exist between any of the aforementioned parties and any director, officer, or employee of IMED, Inc.

#### **REVIEWER REPORT**

I have reviewed the records forwarded on the above injured worker and have answered the questions submitted.

**Information Provided for Review:**

1. Employer's First Report of Injury or Illness.
2. Medical notes from D. Foucy, M.D., dated 09/15/05 through 05/01/06.
3. Physical therapy progress notes dated 10/11/05 through 11/10/05.
4. Lumbar MRI dated 11/30/05.
5. Right knee MRI dated 12/01/05.
6. Right hip MRI dated 12/28/05.
7. Right hip MRI dated 03/07/06.
8. Designated Doctor Evaluation dated 01/05/06.
9. 02/07/06 – Operative report.
10. 04/07/06 – Pain management notes from M. Oliva, M.D.
11. Nerve conduction and EMG study dated 04/19/06.
12. Lumbar spine myelogram dated 04/27/06.
13. Designated Doctor Evaluation dated 05/22/06.
14. Surveillance video dated 05/30/06.
15. Surveillance video dated 06/15/06.
16. Notes from Cotton Merritt, D.C., dated 06/26/06.
17. Independent Medical Evaluation (IME) dated 07/05/06.
18. Functional Capacity Evaluation (FCE) dated 07/12/06.

**Clinical History Summarized:**

The employee was injured at work on \_\_\_\_\_. The incident occurred when a large second grader ran up to hug her and inadvertently knocked her down to the ground. The employee was 50 years old at the time of her injury, and she complained of low back pain, right hip pain, and right knee pain. The employee had a significant past medical history which involved a meniscus repair along with an ACL repair sometime in 2003 or 2004.

The employee began treating with D. Soucy, M.D., on 09/19/05. This was the same physician who had performed the prior knee surgery, and so she returned to his office. Dr. Soucy documented that the employee was complaining of low back pain along with bilateral hip pain and right knee and right annulus foot pain. A physical examination revealed a morbidly obese female with a height of 5 foot 2 inches and a weight of 171 pounds. The lumbar spine revealed diffuse tenderness but no point tenderness with palpation. Palpation also failed to reveal any point tenderness over the left hip or greater trochanter. However, there was some tenderness reported over the right hip region which was aggravated with resisted adduction. Passive abduction also produced right hip pain.

With regard to the right knee, the examination revealed medial side tenderness but no significant effusion and no patellar grind. The employee was stable in varus and valgus testing. The right foot was determined to have no tenderness.

Radiographs of the lumbar spine, bilateral hips, right knee, and right foot were performed and revealed no evidence of acute or traumatic fracture.

Dr. Soucy originally diagnosed the employee with multiple sprain/strain injuries and a possible right knee meniscus injury. Conservative management was recommended including physical therapy.

Physical therapy notes confirmed that the employee started therapy on 10/11/05 and continued through 11/10/05 with little significant improvement. On 11/10/05, the employee indicated her knee still hurt the same as in previous treatments, but her back was hurting worse.

Oddly enough, a note provided by Dr. Soucy on 11/14/05 suggested the employee indicated to him that her knee was improving with therapy and getting stronger. She did still feel an occasional pop when flexing the knee. She had a sensation of minor instability on occasional walking. The examination still revealed a stable varus and valgus stress test on the right knee. However, there was still medial sided tenderness in the knee but no patellar grinding. The back had minimal tenderness but diffuse soreness, and there were no focal motor or sensory deficits.

Since the employee was experiencing ongoing difficulty with her lumbar spine and knee, multiple diagnostic MRI studies were recommended.

On 11/30/05, an MRI of the lumbar spine was performed and revealed a broad-based disc bulge and/or protrusion at L5-S1 which was displaced more toward the posterior left. The radiologist suggested that this did not clinically correlate with the employee's right side leg complaints. Other findings documented in the lumbar spine MRI included mild arthritic changes of the facet noticeable at L4-L5 and L5-S1. There was no significant central canal or neural foraminal stenosis.

The MRI of the right knee was performed on 12/01/05 and confirmed that the HCL graft previously performed in 2003 was stable. However, there was a moderate sized complex tear of the body of the medial meniscus. Early osteoarthritic changes were also noted in the medial compartment along with patellofemoral chondromalacia.

On 12/07/05, Dr. Soucy again saw the employee and recommended conservative management for the lumbar spine. With regard to the hip complaint, Dr. Soucy simply recommended ongoing

therapy, and for her knee, he recommended an arthroscopic procedure. The employee indicated that she would discuss this with her husband.

The employee underwent a bilateral hip MRI on 12/28/05, and the radiologist indicated both hips were intact.

A follow-up visit with Dr. Soucy on 01/06/06, the employee indicated continued right knee pain in the posterior and medial aspects. Dr. Soucy recommended an arthroscopic repair and the employee agreed.

One day prior to this evaluation by Dr. Soucy, the employee was seen by S. Smith, D.O., for a Designated Doctor Evaluation on 01/05/06. Dr. Smith indicated that Maximum Medical Improvement (MMI) had not been reached. He based his assessment on the fact that the employee was going to be scheduled for surgical repair to the right knee. Of interest is the fact that on 01/05/06, the employee indicated she denied low back pain and right foot pain. This was documented in the Designated Doctor Evaluation narrative.

The employee's surgical repair of the right knee was performed on 02/07/06. Oddly enough, the operative note suggests that there was a preoperative diagnosis of a left knee meniscus tear and a postoperative diagnosis of a left knee meniscus tear. It also suggests that a left knee arthroscopy was performed. However, when reading the procedure detail in the operative narrative, the employee's right knee was draped over the edge of the operating table in a fashion that suggests the right knee had the actual surgical procedure done on it.

Following the surgery, the employee underwent a right hip MRI for a second time on 03/07/06. Again, this was considered to be an essentially unremarkable MRI evaluation of the pelvis and right hip.

The employee continued to complain of ongoing pain in the knee and hip regions and eventually on 04/19/06, she underwent a nerve conduction study and EMG study. The physician confirmed that there was no electrodiagnostic evidence of lumbosacral L4 through S1 on the left or L2 through S1 on the right radiculopathy. The right femoral nerve appeared to be intact also at the groin and thigh. Bilateral sciatic nerves were also intact.

Despite this negative EMG study and nondiagnostic MRI scan, the employee did undergo a lumbar spine myelogram with M. Oliva, M.D. This physician suggested that there was actual nerve root sleeve filling defect and adhesions in the L5-S1 region on the right. These adhesions were apparently lysis on or around 04/27/06 despite the fact that she had absolutely no lumbar spine pain as early as January, 2006.

In early May, 2006, the employee was evaluated by a surveillance video investigator. It was noted on 05/08/06 that the employee was able to perform many duties including bending at the waist and squatting fully at her knees. She did not display any evidence of painful behaviors while being observed. At one point, the employee did utilize crutches and a wheelchair while entering a Hobby Lobby.

On 05/19/06, an additional video surveillance was obtained. The employee was able to stand, walk, use a broom and sweep, bend at the waist, and bend her knees to pick up objects off the ground. The employee did not display any difficulty in movement or range of motion, and she was not wearing any visible braces.

On 05/22/06, the employee was again evaluated by S. Smith, D.O., for a Designated Doctor Evaluation. The employee suggested that she had extreme pain in her right knee which came from her lower back and traveled down in her groin as well. Dr. Smith noted that there was a scar over the right knee. The records suggested that the employee underwent a left knee surgery. Right knee evaluation and/or examination procedures were not performed due to subjective pain complaints by the employee. Dr. Smith suggested MMI had not yet been obtained since she was only three month post surgery following a meniscus repair.

Another surveillance video report was documented on 06/15/06. It appears that the employee was placed under surveillance video on 06/13/06, and at that point, she was noted to bend at the waist and bend at the knees, as well as squat completely down to the ground.

On 06/16/06, the employee began treating with Dr. C. Merritt for chiropractic intervention. His letter of 06/16/06 indicated that he performed an examination. Additionally, he indicated that the employee had not started any postoperative knee rehabilitation due to a recommendation by Dr. Oliva for lumbar injections which were never performed. Apparently, Dr. Merritt indicated that the employee was waiting to begin physical therapy for the knee until after she had her lumbar spine injection.

At the time of Dr. Merritt's chiropractic examination, the primary complaint was right knee pain. This pain was listed as 4-6/10 and there was also a secondary complaint of low back pain which was also listed as 4/10.

During the physical examination portion of the chiropractic examination, Dr. Merritt suggested that the employee had a positive McMurray's test suggesting a current tear in the meniscus of the right knee. Dr. Merritt also diagnosed the employee with a lumbar sprain/strain injury and recommended supervised physical therapy as well as a home exercise program.

A preauthorization request was also dated 06/26/06, and in this preauthorization request, Dr. Merritt made a statement that the ODG TWC Guidelines recommended physical therapy for postoperative treatment. However, this is a misleading statement since the Official Disability Guidelines-Treatment and Workers' Guidelines updated as of 2006 actually do not make any such statement. In fact, the only statement regarding meniscus injury and/or rehabilitation is "Controversy exists about the effectiveness of physical therapy after arthroscopic partial meniscectomy".

It appears that another Designated Doctor Evaluation and/or Required Medical Evaluation was performed by H. Ratliff, M.D., on 07/05/06. Curiously, Dr. Ratliff shared the same office as Dr. Smith who performed the prior Designated Doctor Evaluation. Dr. Ratliff performed a much more thorough review of the history and documented the events very accurately including a correct of the typographical error documented on the February, 2006 operative note for the right knee surgery. Another correction and/or update documented by Dr. Ratliff was that the employee did actually undergo an epidural steroid injection on 08/27/06. However, this did not make any sense since Dr. Ratliff only saw the employee on 07/05/06.

During the evaluation by Dr. Ratliff on 07/05/06, the employee now again complained of low back pain radiating down into her buttocks and groin, as well as lower abdomen region. The pain was listed as constant and rating 9-10/10 on the pain scale. During the actual physical examination, Dr. Ratliff confirmed that the employee was able to reach 90 degrees with regard to a seated straight leg raise. Reflexes were normal at 2+, and there were no signs of focal neurological deficits. Range of motion was considered normal at 60 degrees of flexion, 40 degrees of extension, and 30 degrees of bilateral bending in the lumbar spine. With regard to measurements of the thigh, the right thigh was 49 cm while the left thigh was 50 cm. The right calf was 46 cm while the left calf was 47 cm. At the mid patellar region, the measurements were equal at 43 cm.

With regard to the right and left knee, the employee did have a surgical scar over the right knee along with four arthroscopic punctures around the right knee and none on the left knee. There was no effusion on either knee. According to Dr. Ratliff, there was no evidence of tenderness or crepitation in the knee despite that chondromalacia which was documented by Dr. Soucy. According to the employee on 07/05/06, her knee was doing better at that time. Range of motion was mildly reduced to 120 degrees on the right during flexion, but on the left it was also reduced to 130 degrees, and this is the uninjured knee. The employee had full range of motion at both hips and the ankles.

Dr. Ratliff suggested the employee had a resolved lumbar strain and a resolved right ankle sprain. The employee was also diagnosed with a tear of the medial meniscus on the right knee which was status post surgical repair.

Dr. Ratliff was asked several questions following his Designated Doctor Evaluation and/or Independent Medical Evaluation. He confirmed that the compensable body parts included a lumbar sprain/strain, as well as a right knee and right ankle injury. He also suggested that the employee was suffering from preexisting conditions including chondromalacia and osteoarthritis of the right knee, as well as degenerative changes in the lumbar spine. However, he did still feel that these conditions could have been aggravated by the compensable event.

Even though Dr. Ratliff felt the degenerative conditions of the knee and lumbar spine could have been aggravated by the occupational injury, he also confirmed that as of 07/05/06, they had definitely reached an end treatment point or had resolved by that time.

Another question was asked of Dr. Ratliff with regard to the designated doctor's opinion. Dr. Ratliff did not agree with the prior designated doctor's opinion after reviewing the video surveillance tape that was made available to him. Dr. Ratliff felt that the employee was able to perform many more activities on the video surveillance when she was not being tested when compared to the testing situation on 07/05/06. He felt this was inconsistent.

Dr. Ratliff did suggest that the employee had reached MMI no later than 06/13/06, which was the date of the most recent video surveillance tape. He cited the fact that she demonstrated an ability to stand, walk, bend, squat, and lift, as well as climb into a large SUV.

The impairment rating was based on a 5% impairment to the lumbar spine due to mild reduction in lumbar extension. It placed the employee into a DRE Category II. With regard to the knee, there was no impairment based on range of motion, but a 1% impairment was provided for partial meniscectomy and a 2% impairment was awarded for atrophy of the right thigh and calf, even though there was only 1 cm in difference. A total knee impairment of 3% whole body was combined with a 5% impairment to the lumbar spine which equated to an 8% whole person impairment rating.

Dr. Ratliff next indicated that he felt the employee could return to work full-time as a teacher.

A Functional Capacity Evaluation was then performed on 07/12/06 at the recommendation of Dr. Ratliff, and this suggested that the employee gave consistent effort, but she was only able to perform in a sedentary occupation.

**Disputed Services:**

Preauthorization denied for physical therapy right knee three times a week for four weeks to include CPT Codes 97140 and 97110.

**Decision:**

Denial upheld for physical therapy right knee three times a week for four weeks to include CPT Codes 97140 and 97110.

**Rationale/Basis for Decision:**

This employee underwent a right knee meniscectomy on 02/07/06. This is approximately six months status post arthroscopy. The employee had minimal range of motion deficits in the right knee compared to the left knee upon examination by Dr. Ratliff on 07/05/06. There was no evidence of focal neurologic deficits and no significant weakness noted by Dr. Ratliff. Based upon this examination which was benign with regard to the employee's right knee in conjunction with multiple video surveillance sessions which confirm the employee's ability to move with no inhibitions at both the lumbar spine and the knee, there does not appear to be any clear medical indication for supervised physical therapy at this point.

With regard to the statements made by Cotton Merritt, D.C., that the online *Official Disability Guidelines* recommend postoperative care for meniscectomy, this statement is inaccurate. The 2006 updated *ODG Guidelines* do not recommend physical therapy for meniscus surgeries. In fact, it is reported that controversy exists about the effectiveness of physical therapy after arthroscopic partial meniscectomy. The *ODG Guidelines* goes on to state, "Both aerobic walking and home-based quadriceps strengthening exercise reduce knee pain and disability but no difference between them was found".

In summary, denial of the preauthorization request for physical therapy of the right knee for three times a week for four weeks to include CPT Code 97140 and 97110 is upheld.

The rationale for the opinion stated in this report is based on the record review, above mentioned guidelines, as well as the broadly accepted literature to include numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with IMED, Inc. is deemed to be a DWC decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

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If you are disputing the decision, the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than thirty (30) days after the date on which the decision that is the subject of the appeal is final and appealable.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the respondent, the requestor, DWC, and the injured worker via facsimile or U.S. Postal Service this 9<sup>th</sup> day of August, 2006 from the office of IMED, Inc.

Sincerely,

A handwritten signature in cursive script that reads "Charles Brawner".

Charles Brawner  
Secretary/General Counsel