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DATE OF REVIEW: 11/18/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Services rendered on 03/14/08

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

This case was reviewed by a Texas licensed MD, specializing in Physical Medicine & Rehabilitation. The physician advisor has the following additional qualifications, if applicable:

ABMS Physical Medicine & Rehabilitation

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Services rendered on 03/14/08	97750	03/14/2008	Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant reportedly sustained an injury on xx/xx/xx. Reportedly, he was sitting in the back of an truck in a restrained position with a seatbelt when the vehicle rolled over in a motor vehicle accident. There was a fatality involved at the time of the incident. He complained of right lower extremity pain and was evaluated by Fire Department.

Reportedly, he was evaluated in the emergency room and was released. There was no information available or documentation revealing any mode of injury other than suspected contusions. There was no emergency room physician report describing any specific major trauma.

A peer review by Dr. on 02/16/2008 was reviewed. He opined that evidence revealed a contusion injury with no documentation supporting any other significant injury. He had no information on documentation that further treatment was necessary. He did not give any specific restrictions regarding that injury date.

There was a Functional Capacity Evaluation at Center on 3/14/08 reporting inability to meet medium physical demand level of function regarding his gainful employment as an and
. Discussion at the functional capacity evaluation revealed x-rays and MRI was conducted under the care of a chiropractor. The functional capacity assessment reported functional deficits that did not correspond with the right lower extremity; there was reported range of motion deficits to the cervical spine and lumbosacral spine which would not involve the right lower extremity. This reported restriction was regarding grasping that would not involve the right lower extremity injury.

Chiropractic notes dated 01/14/08 revealed that the claimant came to the clinic complaining of rib pain.

He was having minimal discomfort to the right leg. Examination revealed subjective tenderness along the right thoracic region. No objective range of motion deficits. No focal neurological deficits. Conservative care with passive modalities was utilized.

The notes from 01/18/08 revealed ongoing subjective complaints were noted with reports of subjective tenderness to the thoracic region. No objective range of motion deficits. No focal strength loss. No objective functional deficits were reported. Conservative care with passive modalities was continued.

Progress notes dated 11/19/07, 11/26/07, 11/28/07, 11/30/07, 12/05/07, 12/05/07, 12/07/07, 12/10/07, 12/12/07, 12/14/07, 12/17/07, 12/19/07, 12/28/07, 01/02/08, 01/07/08, 01/09/08, 01/21/08, 01/23/08, 01/28/08, 01/30/08, 02/04/08, 02/06/08, 02/11/08, 02/13/08, 02/18/08, 02/20/08, 02/25/08, 02/29/08, 03/03/08, 03/05/08, 03/10/08, 03/12/08, 03/17/08, 03/19/08, 03/24/08 indicated subjective tenderness to the spine and mainly in thoracic region and also interim periods of right leg pain. There were no objective range of motion deficits described. There was no focal neurological deficit described. No objective measurements of strength loss reported. He underwent passive modalities with ultrasound, electrical stimulation, as well as chiropractic manipulations. He also underwent acupuncture for a period of time as well during the treatment.

Disputed Services: Treatment rendered on 03/14/08.

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

This reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute, as stated, were not medically necessary in this case.

Documentation submitted does not support anything other than suspected contusion and sprain/strain injuries to the right lower extremity and spine of which there is no documentation from the treating medical provider which supports lack of healing from this injury as of xx/xx/xx. Treatment by the chiropractic facility noted above reported no measured functional deficits for several months prior to the FCE. Injured worker was noted to be independent with therapeutic exercise for several months prior to the FCE.

Exercise	Recommended. Therapeutic exercises are beneficial for knee osteoarthritis. (Philadelphia, 2001) (Cheing, 2004) (de Jager, 2004) (Roddy, 2005) (Karatosun,

	2005) (Bennell, 2005) Both aerobic walking and home-based quadriceps strengthening exercise reduce knee pain and disability, but no difference between them was found. (Roddy2, 2005) Knee injuries can be reduced by 50 percent after a rigorous warm-up routine. In a study of 1,837 student athletes, acute knee injuries occurred in only 2 percent of athletes in the warm-up group and 4.3 percent in the control group. This warm-up routine included a series of exercises specifically designed to improve muscle awareness, balance, and strength. Typical stretching protocols did not decrease injury. (Olsen, 2005) This review demonstrated an absence of evidence to support one form of exercise intervention against another in the management of isolated ACL injuries. (Trees, 2005) A randomised controlled trial of the effectiveness of water-based exercise concluded that group-based exercise in water over 1 year can produce significant reduction in pain and improvement in physical function in adults with lower limb arthritis, and may be a useful adjunct in the management of hip and/or knee arthritis. (Cochrane, 2005) For exercises and other structured activities pursued with a goal of health improvement, the OASIS group states with a high level of scientific evidence that they have a favorable effect on pain and function in the sedentary knee osteoarthritis (OA) patient, they recommend the practice of exercises and other structured activities for the sedentary patient with knee OA (grade A). Static exercises are not favored over dynamic exercises; availability, preference and tolerance being the criteria for the choice of an exercise (grade A). As results deteriorate when exercises are stopped, they should be performed at a frequency of between one and three times per week (grade B). Professional assistance can be useful in improving initial compliance and perseverance (grade B). There is no scientific argument to support halting exercise in case of an OA flare-up (grade C). (Vignon, 2006) Presurgical exercise improves recovery after hip or knee replacement. Men and women with end-stage osteoarthritis can safely participate in and benefit from a program of cardiovascular fitness, strength training, and flexibility exercise prior to total hip or total knee arthroplasty, according to results of a prospective, randomized trial. (Rooks, 2006) This study supports recommending regular moderate physical activity without undue fear that such activity may increase the risk for knee osteoarthritis (OA). Among middle-aged and elderly persons without knee OA in the Framingham Offspring Study cohort, recreational exercise neither protected against nor increased risk for knee OA. Recreational walking, jogging, frequency of working up a sweat, or high activity levels relative to peers were not associated with decreased or increased risk for OA or with joint space loss. Overweight persons in this cohort had no increases in risk for OA with different types of recreational activity. (Felson, 2007) Current evidence supports the effectiveness and safety of moderate- to high-intensity aerobic and strengthening exercises for osteoarthritis and stable rheumatoid arthritis; participation in recreational activities does not replace the need for therapeutic exercises. (Westby, 2006) Exercise therapy is effective in improving symptoms of knee osteoarthritis, but its effect on structural change remains unclear. This study found that greater muscle strength and endurance fitness, especially in women, may be protective against cartilage loss, but it also may result in a maladaptive enlargement of subchondral bone in both sexes, suggesting that physical activity may have both good and bad effects on the knee. (Foley, 2007) Increased vigorous physical activity is associated with lower mortality (from all causes, not just knee problems). A total of 559,898 American men and women, aged 50 to 71 years, were followed for 10 years. The researchers compared those who rarely engaged in vigorous physical activity (defined as 20 minutes/session, accepted as minimum duration for health benefits) with those who engaged in 20 minutes of vigorous physical activity 1 to 3 times per month, 1 to 2 times per week, 3 to 4 times per week, and 5 or more times per week. For women, the relative risks of mortality (95% confidence interval) were 0.76, 0.72, 0.65, and 0.63, respectively; for men, relative risks were 0.76, 0.68, 0.61, and 0.57. (Leitzmann, 2007) Neuromuscular training may reduce risk factors that contribute to ACL injury. (Myer, 2007) Therapeutic exercise is likely to help with the signs and symptoms of OA. (Stitik, 2007) The combined use of hyaluronate injections with a home exercise program should be considered for management of moderate-to-severe pain in patients with knee osteoarthritis. (Stitik, 2007) Long-term training aimed at increasing muscle fiber size (i.e., strength training) should be preferred over aerobic training to countermeasure the loss of muscle mass and contractile contractile rate

	of force development (RFD) with increasing age. (Aagaard, 2007) Supervised therapeutic exercise improves outcomes in patients who have osteoarthritis or claudication of the knee. Compared with home exercise, supervised therapeutic exercise has been shown to improve walking speed and distance. (Rand, 2007) An 8-week exercise program was associated with relief of symptoms and reduced fatigue in patients with arthritis, according to a randomized controlled trial reported in the January issue of Arthritis Care & Research. A previous small study suggested that both aquatic-based and land-based exercise could improve functional fitness, activities of daily living, and upper extremity strength vs control therapy. The current study finds that the PACE program can relieve pain and reduce fatigue among patients with arthritis at 2 and 6 months. The PACE program also improved self-efficacy of arthritis management, but it did not improve levels of physical activity. (Callahan, 2008) A literature review of strength training for treatment of osteoarthritis (OA) of the knee found that the development of knee OA depends on a variety of factors, with quadriceps weakness being one of the main factors that was modified by resistance training. More than half of the studies found an improvement in self-reported pain and 79 percent found an improvement in self-reported disability/mobility following resistance training, with progressive resistance training associated with an overall increase in physical activity levels. Resistance training included resistance machines, free weights, isometric exercise or other devices such as elastic bands. (Lange, 2008)
Physical medicine treatment	Recommended. Positive limited evidence. As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated. See also specific modalities. (Philadelphia, 2001) Acute muscle strains often benefit from daily treatment over a short period, whereas chronic injuries are usually addressed less frequently over an extended period. It is important for the physical therapy provider to document the patient's progress so that the physician can modify the care plan, if needed. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions (eg, joint range-of-motion and weight-bearing limitations, and concurrent illnesses). (Rand, 2007) Controversy exists about the effectiveness of physical therapy after arthroscopic partial meniscectomy. (Goodwin, 2003) A randomised controlled trial of the effectiveness of water-based exercise concluded that group-based exercise in water over 1 year can produce significant reduction in pain and improvement in physical function in adults with lower limb arthritis, and may be a useful adjunct in the management of hip and/or knee arthritis. (Cochrane, 2005) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term physical therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Lowe, 2007) Supervised therapeutic exercise improves outcomes in patients who have osteoarthritis or claudication of the knee. Compared with home exercise, supervised therapeutic exercise has been shown to improve walking speed and distance. (Rand, 2007) A physical therapy consultation focusing on appropriate exercises may benefit patients with OA, although this recommendation is largely based on expert opinion. The physical therapy visit may also include advice regarding assistive devices for ambulation. (Zhang, 2008) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008) In patients with ACL injury willing to moderate activity level to avoid reinjury, initial treatment without ACL reconstruction should be considered. All ACL-injured patients need to begin knee-specialized physical therapy early (within a week) after the ACL injury to learn more about the injury, to lower the activity level while performing neuromuscular training to restore the functional stability, and as far as possible avoid further giving-way or re-injuries in the same or the other knee, irrespectively if ACL is reconstructed or not. (Neuman, 2008) Limited gains for most patients with knee OA. (Bennell, 2005) More likely benefit for combined manual physical therapy and supervised exercise for OA. (Deyle, 2000) Many patients do not require PT after partial meniscectomy. (Morrissey, 2006) There are short-term gains for PT after

	TKR. (Minns Lowe, 2007) See also specific physical therapy modalities by name, as well as Exercise. **ODG Physical Medicine Guidelines –** Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Sprains and strains of knee and leg; Cruciate ligament of knee (ACL tear) (ICD9 844; 844.2):
Medical treatment: 12 visits over 8 weeks

Physical medicine treatment	Recommended as indicated below. A physical therapy program that starts immediately following hip injury or surgery allows for greater improvement in muscle strength, walking speed and functional score. (Jan, 2004) (Jain, 2002) (Penrod, 2004) (Tsauo, 2005) (Brigham, 2003) (White, 2005) (National, 2003) A weight-bearing exercise program can improve balance and functional ability to a greater extent than a non-weight-bearing program. (Expert, 2004) (Binder, 2004) (Bolgla, 2005) (Handoll, 2004) (Kuisma, 2002) (Lauridsen, 2002) (Mangione, 2005) (Sherrington, 2004) Patients with hip fracture should be offered a coordinated a multidisciplinary rehabilitation program with the specific aim of regaining sufficient function to return to their pre-fracture living arrangements. (Cameron, 2005) A physical therapy consultation focusing on appropriate exercises may benefit patients with OA, although this recommendation is largely based on expert opinion. The physical therapy visit may also include advice regarding assistive devices for ambulation. (Zhang, 2008) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008) ODG Physical Medicine Guidelines – Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less). Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface. **Sprains and strains of hip and thigh** (ICD9 843): 9 visits over 8 weeks

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG: knee/leg chapter