



DATE OF REVIEW: April 1, 2009

IRO Case #:

Description of the services in dispute:

This is a request for physical therapy for the lumbar and right knee 3 x 4 weeks.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Physical Medicine and Rehabilitation. This reviewer has been in active practice since 2005.

Review Outcome

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

Based on ODG Guidelines, the request for physical therapy for the lumbar/right knee 3 x 4 weeks is not medically necessary.

Information provided to the IRO for review

Patient clinical history [summary]

The patient is female who was injured while working as a. She was walking into a doorway and slipped and fell and sustained injury to both knees with abduction of the right thigh. She had x-rays taken at the time of the injury which showed no significant fractures or dislocation. Her diagnosis was right hip pain and she returned to full duty back to work.

On 11/15/06 she had x-rays of the right tibia that showed no evidence of fracture or dislocations.

EMG testing done around the same time frame showed no evidence of bilateral lower extremity radiculopathy.

She was treated with physical therapy for her injuries and received a total of 9 physical therapy

visits throughout the duration of her care.

She had a designated doctor RME examination on 02/14/07 which showed her to be at maximum medical improvement.

On 03/23/07 the patient began seeing Dr.. That time she complained of persistent pain in her right hip and right buttock which extends to anterior knee pain with some development of pain in the anterior lower leg in the area of the tibia. She has continued to work full time at since the injury. Past medical history was negative and past surgical history included lung surgery and there were no allergies. Physical examination showed her oriented to person, place and time. Multiple muscle spasms in the lumbar area at the lumbosacral junction were noted. There is positive straight leg raise at the right and mildly positive on the left. There is good range of motion of the hips. There is some pain with hyper flexion of the knee. Assessment was right leg sciatica. Plan was to obtain an MRI. The assessment was right knee pain recommended that this was a separate entity and rule out possibility of meniscal tear with MRI of the right knee as well. She will continue physical therapy.

On 03/29/07 she had an MRI of the right knee which showed superior surface undersurface tears of the posterior horn and medial meniscus with myxoid and degeneration. MRI of the lumbar spine showed tiny central angular tear at L1-2, a small central HNP at L2-3 with no extrusion, no evidence of significant canal or foraminal stenosis throughout.

The patient continued to see Dr. over the next several months and there was great difficulty obtaining approval for ESIs to treat her chronic condition.

The patient was eventually released from care from Dr. because of frequent denial from the carrier and began being seen by Dr., Doctor of Chiropractic, shortly thereafter. She was taken off work for a brief period of time for chiropractic care without significant improvement.

On 04/17/08 the patient was seen by Dr. for evaluation and treatment. The conclusion remained the same for approval of lumbar epidural steroid injections.

A benefit review conference was held on 07/31//08 with an addendum submitted on 08/07/08. Dr. opines that the compensable injuries include right hip strain, annular tear at L1/2, HNP at L2/3, right knee strain, and tears of the posterior horn of the medial meniscus of the right knee.

The records indicate the patient was receiving chiropractic treatment from D.C.

Dr. has followed Mrs. since this time and the most recent medical note we have is 02/23/09. At that time she continues to have severe pain in her lumbar region with pain radiating to both hips and both lower extremities. He commented on the MRI scan of 2007 but no new MRIs since then. The recommendation was for her to undergo a new MRI scan and further evaluate her case and disposition. Examination showed difficulty bending to reach for her knees and pain in the lumbar area. She had difficulty walking on her heels and toes. Plan was to obtain authorization for another MRI of the lumbar spine. A note dated 01/13/09 reports the patient injured levels L1-2 and L2-3 and it is recommended that a further (repeat) MRI scan include those levels. It is also recommended that time that the patient undergo additional physical therapy treatments 3x wk x4wks.

The request for physical therapy was initially reviewed by Dr. on 02/18/09. Dr. reports that the patient has previously received physical therapy early in the course of her treatment. She reports that it is not reasonable to expect any significant improvement 2 ½ years post date of injury and there is a reasonable expectation of independence on home exercise program and return to work.

The request was appealed and subsequently reviewed by Dr. on 03/04/09. Dr. opines that there is inadequate reason for additional monitored physical therapy and that the patient should be well versed in a home exercise program. Dr. upholds the previous determination.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

Items in Dispute: Physical therapy for the lumbar and right knee 3 x 4 weeks

The request for physical therapy for the lumbar/right knee 3 x 4 weeks is not medically necessary and the previous determinations upheld. The patient is a female who sustained injuries to knee and back as the result of a slip and fall. The records indicate that she has undergone extensive conservative treatment which has include physical therapy and passive modalities provided by a Doctor of Chiropractic. The patient has far exceeded the current evidenced based recommendations in the Official Disability Guidelines. The ODG would support 10 sessions of physical therapy for a diagnosis of a lumbar strain or intervertebral disc disorder. In regards to the diagnosis of right knee strain and meniscal injury the ODG would support 9-12 sessions depending on the diagnosis. It is reasonable to expect the patient to be capable of performing a daily self directed home program and further physical therapy would not be supported unless the patient is taken to surgery.

A description and the source of the screening criteria or other clinical basis used to make the

decision:

The Official Disability Guidelines, 13th edition, The Work Loss Data Institute.

Knee: 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) Physical therapy and patient education

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may be underused as treatments for knee pain, compared to the routine prescription of palliative medication. (Mitchell, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) 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.

Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5):

Medical treatment: 9 visits over 8 weeks

Post-surgical (Meniscectomy): 12 visits over 12 weeks

Sprains and strains of knee and leg; Cruciate ligament of knee (ACL tear) (ICD9 844; 844.2):

Medical treatment: 12 visits over 8 weeks

Post-surgical (ACL repair): 24 visits over 16 weeks

Old bucket handle tear; Derangement of meniscus; Loose body in knee; Chondromalacia of patella;

Tibialis tendonitis (ICD9 717.0; 717.5; 717.6; 717.7; 726.72):

9 visits over 8 weeks

Post-surgical: 12 visits over 12 weeks

Pain in joint; Effusion of joint (ICD9 719.0; 719.4):

9 visits over 8 weeks

Arthritis (Arthropathy, unspecified) (ICD9 716.9):

Medical treatment: 9 visits over 8 weeks

Post-injection treatment: 1–2 visits over 1 week

Post-surgical treatment, arthroplasty, knee: 24 visits over 10 weeks

Abnormality of gait (ICD9 781.2):

16–52 visits over 8–16 weeks (Depends on source of problem)

Fracture of neck of femur (ICD9 820):

Post-surgical: 18 visits over 8 weeks

Fracture of other and unspecified parts of femur (ICD9 821):

Post-surgical: 30 visits over 12 weeks

Fracture of patella (ICD9 822):

Post-surgical: 10 visits over 8 weeks

Fracture of tibia and fibula (ICD9 823)

Medical treatment: 30 visits over 12 weeks

Post-surgical treatment (ORIF): 30 visits over 12 weeks

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Amputation of leg (ICD9 897):

Post-replantation surgery: 48 visits over 26 weeks

Work conditioning (See also Procedure Summary entry):

12 visits over 8 weeks

The Official Disability Guidelines, 13th edition, The Work Loss Data Institute.

Lumbar: Physical Therapy.

Recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. See also Exercise. Direction from physical and occupational therapy providers can play a role in this, with the evidence supporting active therapy and not extensive use of passive modalities. The most effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle-strengthening exercises seem to be the most effective types of exercises for treating chronic low back pain. (Hayden, 2005) Studies also suggest benefit from early use of aggressive physical therapy ("sports medicine model"), training in exercises for home use, and a functional restoration program, including intensive physical training, occupational therapy, and psychological support. (Zigenfus, 2000) (Linz, 2002) (Cherkin-NEJM, 1998) (Rainville, 2002) Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. (Mannion, 2001) (Jousset, 2004) (Rainville, 2004) (Airaksinen, 2006) One clinical trial found both effective, but chiropractic was slightly more favorable for acute back pain and physical therapy for chronic cases. (Skargren, 1998) A spinal stabilization program is more effective than standard physical therapy sessions, in which no exercises are prescribed. With regard to manual therapy, this approach may be the most common physical therapy modality for chronic low back disorder, and it may be appropriate as a pain reducing modality, but it should not be used as an isolated modality because it does not concomitantly reduce disability, handicap, or improve quality of life. (Goldby-Spine, 2006) Better symptom relief is achieved with directional preference exercise. (Long, 2004) As compared with no therapy, physical therapy (up to 20 sessions over 12 weeks) following disc herniation surgery was effective. Because of the limited benefits of physical therapy relative to "sham" therapy (massage), it is open to question whether this treatment acts primarily physiologically, but psychological factors may contribute substantially to the benefits observed. (Erdogmus, 2007) See also specific physical therapy modalities, as well as Exercise; Work conditioning; Lumbar extension exercise equipment; McKenzie method; & Stretching. [Physical therapy is the treatment of a disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, activities of daily living and alleviating pain. (BlueCross BlueShield, 2005) As for visits with any medical provider, physical therapy treatment does not preclude an employee from being at work when not visiting the medical

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provider, although time off may be required for the visit.]

Active Treatment versus Passive Modalities: The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with acute low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz,

2007) The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530).

Patient Selection Criteria: Multiple studies have shown that patients with a high level of fear-avoidance do much better in a supervised physical therapy exercise program, and patients with low fear-avoidance do better following a self-directed exercise program. When using the Fear-Avoidance Beliefs Questionnaire (FABQ), scores greater than 34 predicted success with PT supervised care. (Fritz, 2001) (Fritz, 2002) (George, 2003) (Klaber, 2004) (Riipinen, 2005) (Hicks, 2005) Without proper patient selection, routine physical therapy may be no more effective than one session of assessment and advice from a physical therapist. (Frost, 2004) Patients exhibiting the centralization phenomenon during lumbar range of motion testing should be treated with the specific exercises (flexion or extension) that promote centralization of symptoms. When findings from the patient's history or physical examination are associated with clinical instability, they should be treated with a trunk strengthening and stabilization exercise program. (Fritz-Spine, 2003)

Post Epidural Steroid Injections: ESIs are currently recommended as a possible option for short-term treatment of radicular pain (sciatica), defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The general goal of physical therapy during the acute/subacute phase of injury is to decrease guarding, maintain motion, and decrease pain and inflammation. Progression of rehabilitation to a more advanced program of stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based research that addresses the use of physical therapy post ESIs, but it appears that most randomized controlled trials have utilized an ongoing, home directed program post injection. Based on current literature, the only need for further physical therapy treatment post ESI would be to emphasize the home exercise program, and this requirement would generally be included in the currently suggested maximum visits for the underlying condition, or at least not require more than 2 additional visits to reinforce the home exercise program. ESIs have been found to have limited effectiveness for treatment of chronic pain. The claimant should continue to follow a home exercise program post injection. (Luijsterburg, 2007) (Luijsterburg2, 2007) (Price, 2005) (Vad, 2002) (Smeal, 2004)

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ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more 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, including assessment after a "six-visit clinical trial".

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):

10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846):

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5):

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1–2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

Intervertebral disc disorder with myelopathy (ICD9 722.7)

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis (ICD9 724.0):

10 visits over 8 weeks

See 722.1 for post-surgical visits

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):

10–12 visits over 8 weeks

See 722.1 for post-surgical visits

Curvature of spine (ICD9 737)

12 visits over 10 weeks

See 722.1 for post-surgical visits

Fracture of vertebral column without spinal cord injury (ICD9 805):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury (ICD9 806):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Work conditioning (See also Procedure Summary entry):

10 visits over 8 weeks

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