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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/28/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 3 X 4 Head

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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

OD Guidelines

Denial Letters 6/18/09 and 6/30/09

Dr. 4/29/09 and 4/24/09

4/21/09 thru 5/5/09

PT Eval 5/7/09

PT Progress Report 5/28/09

PT Today 6/1/09 thru 6/8/09

Dr. 6/17/09

PATIENT CLINICAL HISTORY SUMMARY

This xx-year-old man fell from a 10 foot ladder on x/xx/xx. He sustained a subdural hematoma that was treated without surgery. There was no residual paralysis. He had compression fractures at L1, L2, L3 and possibly a C1 fracture (that was mentioned once and no treatment was described. He had rib fractures and shoulder pain. His main problem was a

tibia fibula fracture for which he underwent surgery on 4/17. He reportedly had difficulty walking. The initial therapy note of 5/7 described his walking 500 feet independently with a straight cane on level ground and 200 feet with SBA on uneven ground. He had no neurological loss. The goal was to improve his walking to 1500 feet without any assistive device and to reduce pain with self-dressing. Dr. said he was using a quad cane for walking. The tibia fibula fracture had been healing.

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

He sustained multiple injuries. He fortunately had no neurological sequelae of the head injury. The therapies in the head injury section of the ODG did not appear applicable. His main functional loss is in the tibia fibula fracture and how it affects his walking. The therapies were addressing his back pain more than his walking. The ODG permits up to 30 sessions over 12 weeks. He is now 15 weeks post injury, but the request for the additional therapy was 9 weeks post injury. The therapy for the compression fracture was for 8 visits over 10 weeks, but he had the additional injuries cited above. The ODG would have permitted the additional 3 weeks of therapy at 3 times a week for walking, but the request is for 4 weeks. Further, additional treatment can be approved for abnormal gait patterns, although this replicates to some extent the leg fracture. The reviewer's assessment is that the additional therapy sessions can be justified due to the extent of injuries and overlapping issues.

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 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](#).

Abnormality of gait (ICD9 781.2):

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

Fracture of tibia and fibula (ICD9 823)

Medical treatment: 30 visits over 12 weeks

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

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".

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

Medical treatment: 8 visits over 10 weeks

Physical medicine treatment

Recommended. Patient rehabilitation after traumatic brain injury is divided into two periods: acute and subacute. In the beginning of rehabilitation physical therapist evaluates patient's functional status, later he uses methods and means of treatment, and evaluates effectiveness of rehabilitation. Early ambulation is very important for patients with coma. Physical therapy consists of prevention of complications, improvement of muscle force, and range of motions, balance, movement coordination, endurance and cognitive functions. Early rehabilitation is necessary for traumatic brain injury patients and use of physical therapy methods can help to regain lost functions and to come back to the society. ([Colorado, 2005](#)) ([Brown, 2005](#)) ([Franckeviciute, 2005](#)) ([Driver, 2004](#)) ([Shiel, 2001](#))

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](#).

Fracture of skull (ICD9 801):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Headache (ICD9 784.0):

6 visits over 6 weeks

Tension headache (ICD9 307.81):

6 visits over 6 weeks

Hemiplegia and hemiparesis (ICD9 342):

Acute inpatient phase: 20-40 visits over 4 weeks

Subacute phase: 6-12 visits over 12 weeks

Bell's palsy (ICD9 351.0):

8 visits over 4 weeks

Temporomandibular joint disorders (ICD9 524.6):

6 visits over 4 weeks

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)