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DATE OF REVIEW: 07/06/09

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional physical therapy of 12 visits to the right knee

REVIEW OUTCOME

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

Overtuned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 04-29-09 Daily Progress report from PT
- o 05-22 09 Evaluation report from Dr.
- o 05-22-09 Therapy referral from Dr. for loss of full extension
- o 06-01-09 Re-evaluation report from PT
- o 06-05-09 Notification of Determination letter
- o 06-10-09 Fax cover request for PT from Dr.
- o 06-17-09 Reconsideration review determination
- o 06-17-09 Request for IRO from Dr.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a employee who sustained an industrial injury to the right knee on xx-xx-xx when another employee ran over his knee pushing a cart. He is status post ACL reconstruction surgery on October 1, 2008 with allograft and is followed orthopedically for continuing right knee complaints.

Physical therapy notes of April 29, 2009 notes the patient is improving with PT. The patient has good compliance with an extensive home exercise program and knee range of motion has been improved. He notes mild stiffness in the AM. His exercise weights will be increased.

An additional 8-12 visits of therapy is ordered on May 22, 2009 for loss of knee extension 8 months post-op right ACL reconstruction.

The patient was reevaluated on May 22, 2009. He does not feel instability at this time. He has made remarkable progress but has lost some of his extension that he had before. He is minus about 8 degrees of active extension. He has full extension passively but with significant discomfort. He has obviously scarred down significantly which can likely be improved with therapy.

No mechanical block is felt. It will be difficult for him to realize full extension. He will never be fully functional until he gets full extension.

The patient was reevaluated in PT on June 1, 2009. He has had several months of PT but currently PT is being denied. His chief complaint is intermittent right anterior knee pain, usually only with knee extension and ambulation. He has some discomfort with

kneeling, squatting and bending the knee. He has stiffness in the AM. He occasionally uses a home electrical stim unit for pain and swelling. On examination, there is no swelling. He has mild difficulty with gait and stairs. There is tenderness in the area of the pes anserine in the medial knee. No extensor lag is seen. He demonstrated a good quad set. He is slightly limited in flexion and extension. Orthopedic testing is negative. Recommendation is for an additional 6 visits.

Request for additional physical therapy of 12 visits to the right knee was not certified in review on June 5, 2009 following an attempted peer discussion, with rationale that the documents contain little information to support the request. ODG recommends 24 visits of PT for the patient's diagnosis. The patient has completed 28 sessions of PT with mild stiffness noted in the AM, limitations of ROM, gait, balance deficits with weakness and loss of full extension. Lacking opportunity of a peer discussion to clarify any additional rationale, the request could not be recommended.

Request for reconsideration was made on June 10, 2009.

Request for reconsideration for additional physical therapy of 12 visits to the right knee was not certified in review on June 17, 2009 with rationale that the total amount of PT provided was not clear. Additionally the claimant's response to PT was not clarified in regard to pain relief, increase in range of motion or restoration of function. There was not a clear plan allowing for fading of treatment or an active plan for self directed PT.

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

The patient is 8 months post ACL repair of the right knee and has participated in approximately 28 post-operative sessions of physical therapy. On April 29 the patient is noted to have good compliance with an extensive home exercise program and knee range of motion has been improved. On May 22 he is minus about 8 degrees of active extension. He has full extension passively but with significant discomfort and is assessed as having scar tissue. The PT reassessment of June 1, 2009 notes, no swelling, mild difficulty with gait and stairs, tenderness in the area of the pes anserine in the medial knee, no extensor lag, slight limitation in flexion and extension, and negative orthopedic testing. He demonstrated a good quad set. The provider is concerned about the long term outcome if the patient does not attend additional formal PT.

Despite an active home exercise program with good compliance noted, the patient appears to have regressed with regard to range of motion. He has full extension passively but with significant discomfort. The provider has noted that it will be difficult for him to realize full extension and will never be fully functional until he gets full extension. The patient appears to have developed adhesions in the post-operative knee. Given the patient's compliance with HEP and continuing range of motion deficit, my recommendation is to disagree with the prior non-certification. Therefore, my recommendation is to overturn the previous non-determination for 12 additional visits of physical therapy. Pending re-evaluation after these sessions, further recommendations can then be made.

The IRO's decision is consistent with the following 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

____ 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

X 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

The Official Disability Guidelines, Knee and Leg, Physical Medicine (6-25-2009):

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.

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). Controversy exists about the effectiveness of physical therapy after arthroscopic partial meniscectomy. 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. 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. 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. 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. 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.

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. Limited gains for most patients with knee OA. More likely benefit for combined manual physical therapy and supervised exercise for OA. Many patients do not require PT after partial meniscectomy. There are short-term gains for PT after TKR. Physical therapy and patient education may be underused as treatments for knee pain, compared to the routine prescription of palliative medication. 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.

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.

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