



5068 West Plano Parkway Suite 122
Plano, Texas 75093
Phone: (972) 931-5100

DATE OF REVIEW: 10/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

IRO - 12 sessions of physical therapy

Amended 10/19/09

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 Orthopedic Trauma, Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

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
IRO - 12 sessions of physical therapy Amended 10/19/09	97035, 97110	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Requestor Records		1		
2	Claim Notes	Dr.	67	05/08/2008	09/08/2009
3	IRO Request	TDI	17	09/28/2009	09/28/2009

4	Appeal Denial Letter		2	09/23/2009	09/23/2009
5	Appeal Denial Letter		3	09/23/2009	09/23/2009
6	Designated Doctor Report	Dr.	17	07/29/2009	07/29/2009
7	Initial Denial Letter		2	09/14/2009	09/13/2009
8	Initial Denial Letter		2	09/11/2009	09/11/2009
9	FCE Report	Physical Therapy	12	08/13/2009	08/13/2009
10	IRO Request	IRO Request	1	09/28/2009	09/08/2009
11	IRO Request	IRO Request	1	09/28/2009	09/28/2009
12	IRO Request	IRO Request	1	09/28/2009	09/28/2009
13	IRO Request	IRO Request	1	09/28/2009	09/28/2009
14	IRO Request	IRO Request	1	09/28/2009	09/28/2009

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female with an injury to her left knee on xx/xx/xx. The mechanism of injury was a slip occurring as the patient stepped out of her truck. She suffered medial and lateral meniscus tears. She has undergone two surgical procedures for meniscal debridement and repair. She has undergone an extensive physical therapy program with 31 sessions reported. There is now a request for additional physical therapy. She continues to report mechanical symptoms of "locking, popping, giving way". She has undergone 2 functional capacity examinations, the last being 07/08/09 and revealing that she functions at a medium physical capacity adequate for the demands of her employment. The medical records include no statement of range of motion, there is effusion, and no instability is documented. The expectations of another series of physical therapy sessions are not documented.

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

There is insufficient medical documentation to justify physical therapy in excess of that recommended in the ODG, 2009, knee chapter cited above. There is no statement of the expectations of additional physical therapy. In fact, there is no documentation of the effect of prior physical therapy treatments. In the absence of documentation to suggest that range of motion of the left knee or strength of the musculature would be benefitted by supervised physical therapy, the request for the additional therapy cannot be approved. Medical necessity has not been established. The prior denials were appropriate and should be upheld.

I reviewed additional information submitted 10/19/09. The principle additional information submitted was a DDE 07/29/09 performed by , MD. The designated doctor found diminished range of motion of the knee. No atrophy of the thigh musculature was demonstrated by circumference measurement. It would appear that this patient can be transitioned into a home program of passive and active stretching, as well as, muscle strengthening. Structured supervised physical therapy has been provided and it does not appear that additional such physical therapy is likely to produce any appreciable improvement that cannot be achieved by a home program. The additional medical records did not alter my opinion as previously stated.

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
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	<p>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) This study sought to clarify which type of postoperative rehabilitation program patients should undergo after ACL reconstruction surgery, comparing a neuromuscular exercise rehabilitation program with a more traditional strength-training regimen, and it showed comparable long-term primary and secondary outcomes between the 2 groups at 12 and 24 months. On the basis of the study, the authors recommend a combined approach of strength exercises with neuromuscular training in postoperative ACL rehabilitation programs. (Risberg, 2009) See also specific physical therapy modalities by name, as well as Exercise.</p> <p>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.</p> <p>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</p>
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG: Knee Chapter