



IMED, INC.

1701 N. Greenville Ave. • Suite 202 • Richardson, Texas 75081
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 09/15/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: 1. Manual electrical stimulation, 15 minutes; 2. Iontophoresis, 15 minutes; 3. Mechanical traction, 15 minutes; 4. Manual therapy, 15 minutes; 5. Therapeutic activities, 15 minutes; 6. Ultrasound, 15 minutes; 7. Hot/cold therapy, 15 minutes; 8. E-stimulation and therapeutic exercise.

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. MRI of the right knee dated 05/28/09
2. MRI of the left knee dated 05/28/09
3. Clinical records, Dr. , 05/26/09 thru 08/26/09
4. Utilization review determination dated 07/27/09
5. Utilization review determination dated 08/26/09
6. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee was described as a xx years old female who was reported to have sustained injuries to her bilateral knees as a result of a slip and fall. The employee was reported to have landed directly onto both knees.

On 05/28/09, the employee was referred for an MRI of the bilateral knees. The MRI of the right knee revealed intact ligamentous structures. There was mild Grade II chondromalacia of the posterolateral tibial plateau and central medial femoral condyle. There was Grade II-III chondromalacia at the patella apex and medial facet, and similar findings were present at the trochlear apex. There was moderate chondromalacia of the patellofemoral compartment, primarily involving the medial patellar facet and medial trochlear facet. The MRI of the left knee revealed no evidence of meniscal tear, cruciate ligament disruption, no bony contusions, mild to moderate chondromalacia of the patellofemoral compartment primarily involving the medial plateau or facet, trochlear apex, and medial trochlear facet. There was minimal chondromalacia of the medial femoral condyle.

On 06/11/09, the employee was seen in follow-up by Dr. . The employee presented to review the MRI. She reported her pain was throbbing and moderate. Her symptoms improved with rest and nonsteroidal anti-inflammatories. Upon physical examination, the employee was 66 inches tall and weighed 236 pounds and had a BMI of 36.01. Upon physical examination of the right knee, the employee had an antalgic gait. She had diffuse tenderness and range of motion is 0-110 degrees. Quadriceps and hamstring strength was graded as 3. Lachman's test was negative and ligamentous structures were normal. Anterior drawer sign was negative. McMurray's test was reported to be positive. There was patellar apprehension. Examination of the left knee revealed an antalgic gait with no effusion, diffuse joint tenderness, range of motion was 0-110 degrees, and quadriceps and hamstring strength was graded as 3. McMurray's test was reported to be positive. There was patellofemoral crepitus and a positive patellar grind test. The employee was provided oral medications which included Darvocet, Ultracet, and Naprelan and was subsequently referred for physical therapy with a diagnosis of chondromalacia patella.

The employee was seen in physical therapy for physical therapy evaluation on 06/19/09.

On 06/26/09, the employee was seen in follow-up by Dr. . Her symptoms remained unchanged. Her physical examination was unchanged.

The employee had six sessions of physical therapy and was seen in follow-up by Dr. on 07/23/09. At that time, it was reported that the employee had progressed in therapy and felt better. Her pain level was reported to be 3/10. Her symptoms were worse when standing, squatting, kneeling, bending, climbing stairs or walking. Upon physical examination, the employee's left knee, quadriceps, and hamstring strength was now reported to be 5- with similar findings in the left knee. The employee was recommended to undergo additional physical therapy.

On 08/20/09, the employee was seen in follow-up by Dr. . At that time, she reported her pain was mild and her pain level remained at a 3/10. She noted improvement with rest, physical therapy, and nonsteroidal anti-inflammatories. The employee's physical examination was essentially unchanged; however, the employee was now reported to have range of motion of 0-120 degrees. No further gains were made in regards to muscle strength. The employee was recommended to undergo twelve additional sessions of physical therapy two times a week for six weeks.

On 07/27/09, a request for additional physical therapy was reviewed by Dr. . Dr. denied the request noting that the employee has completed ten sessions of physical therapy, and that she should be able to perform active home exercise.

A subsequent request was reviewed on 08/26/09 by Dr. and Dr. . This was a request for Visco supplementation and additional physical therapy two times a week for four weeks. Dr. reported that the clinician reported chondromalacia but offered no objective diagnostic evidence of this finding. He noted that hyaluronic acid is only indicated for treatment of arthritis. He reported that the employee had completed the recommended physical therapy.

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

The request for additional physical therapy two times a week for four weeks is not supported by current evidence-based guidelines.

Records indicate that the employee sustained injuries to the bilateral knees as the result of a slip and fall. The employee underwent MRI of the bilateral knees which indicated evidence of bilateral chondromalacia patella with evidence of chondromalacia involving the femoral condyles. Current evidence-based guidelines support nine sessions of physical therapy over eight weeks for the employee's diagnosis. This may be extended to twelve additional visits if operative intervention is performed.

The submitted clinical records indicate that the employee has undergone ten sessions of physical therapy with benefit. Most recent physical therapy notes indicate that the employee's range of motion improved to 120 degrees flexion and motor strength went from 3-5-/5. The employee clearly appears at a point where she could safely perform a daily self-directed home exercise program, and continued physical therapy would not be supported by the official disability guidelines. It is further noted that the **Official Disability Guidelines** do fully support the performance of manual electrical stimulation, iontophoresis, manual traction, ultrasound, or electric stimulation in the treatment of knee injuries. Therapeutic exercises, therapeutic activities, and hot and cold therapy would be considered appropriate if the employee met other criteria.

Based upon the submitted clinical information, the previous denials are upheld.

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

The 2009 Official Disability Guidelines, 14th Edition, The Work Loss Data Institute. Online edition.

Knee Chapter

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

Iontophoresis

Recommended for specific conditions as indicated below. During iontophoresis, an electric current helps deliver ionically charged substances through the skin to reach deeper tissues. Therefore, it may be indicated for calcific tendinopathy, inflammatory conditions, or hyperhidrosis. Compared with usual care, iontophoresis is associated with improved outcomes in patients with myositis ossificans. Contraindications to use of iontophoresis include allergy or sensitivity to the substance being applied, open wounds, or impaired sensation. Iontophoresis also should not be used in the immediate vicinity of metallic implants, wires, or staples. ([Rand, 2007](#))

TENS (transcutaneous electrical nerve stimulation)

Recommended as an option for patients in a therapeutic exercise program for osteoarthritis as a treatment for pain. The addition of TENS plus exercise appears to produce improved function (greater cumulative knee extensor torque, stride length, gait velocity and range of motion) over those treated with exercise only, although the difference has not been found to be significant. ([Philadelphia, 2001](#)) ([Hulme-Cochrane, 2002](#)) ([Ng, 2003](#)) ([Cheing, 2004](#)) ([BlueCross BlueShield, 2005](#)) ([Osiri, 2000](#)) ([Mont, 2006](#)) ([Garland, 2007](#)) Transcutaneous electrical nerve stimulation offers clinically relevant short-term pain relief for osteoarthritis of the knee, according to a report in the June 22nd issue of BMC Musculoskeletal Disorders. ([Bjordal, 2007](#)) Transcutaneous electrical nerve stimulation can help with short-term pain control among patients with hip or knee OA. ([Zhang, 2008](#)) A 6-week program of progressive strength training targeting the quadriceps femoris muscle group substantially improves strength and function following total knee arthroplasty for treatment of osteoarthritis, compared to patients who received standard of care therapy; however, addition of neuromuscular electrical stimulation (NMES) to the strength training exercise did not improve outcomes. ([Petterson, 2009](#))

Ultrasound, therapeutic

Not recommended over other, simpler heat therapies. Therapeutic ultrasound is one of several rehabilitation interventions used for the management of pain due to patellofemoral pain syndrome. One meta-analysis concludes that ultrasound therapy was not shown to have a clinically important effect on pain relief for patients with patellofemoral pain syndrome, although these conclusions are limited by the poor reporting and low methodological quality of the trial included. ([Brosseau-Cochrane,](#)

[2002](#)) ([Bjordal, 2007](#)) One study on the use of therapeutic ultrasound for osteoarthritis of the knee concluded that ultrasound therapy appears to have no benefit over placebo or short wave diathermy for patients with knee osteoarthritis. ([Welch-Cocrane, 2001](#)) In ultrasound therapy, high-frequency sound waves are used to warm superficial soft tissues or with the intention of facilitating tissue healing at the cellular level. Ultrasound heating may be useful for tendon injuries or for short-term pain relief of muscle strain or spasm, but it should not be used near malignant tumors, nerve tissue in a patient who has recently had a laminectomy, joint replacements, permanent pacemakers, thrombophlebitis, eyes, reproductive organs, areas of acute inflammation, epiphyseal plates, or over breast implants. For Olympic athletes, exemption is needed for use of ultrasound. ([Rand, 2007](#))