

# P&S Network, Inc.

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## Notice of Independent Review Decision

### MEDICAL RECORD REVIEW:

**DATE OF REVIEW:** April 12, 2010

**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**

12 sessions of physical rehabilitation

### **REVIEW OUTCOME**

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

Upheld (Agree)

### **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 05-26-09 Right knee MRI read by Dr.
- o 05-26-09 Right knee radiographs read by Dr.
- o 06-24-09 Consultation report from Dr.
- o 08-18-09 Orthopedic Consultation report from Dr.
- o 09-04-09 Consultation report from Dr.
- o 10-14-09 Consultation report from Dr.
- o 10-30-09 Orthopedic Report from Dr.
- o 11-18-09 Pre-op chest x-ray read by Dr.
- o 11-18-09 Operative Report for knee surgery from Dr.
- o 11-24-09 Orthopedic Report from Dr.
- o 12-07-09 Consultation report from Dr.
- o 12-09-09 First of 28 Daily Progress Note [for treatment visits 12-9-09 to 03-03-10]
- o 01-05-10 Orthopedic Report from Dr.
- o 01-18-10 Physical Therapy Evaluation from Dr.
- o 01-27-10 Consultation report from Dr.
- o 02-09-10 PT progress note from Dr.
- o 02-16-10 Orthopedic Report from Dr.
- o 03-01-10 Physical therapy progress noted from Dr.
- o 03-03-10 28th Daily Progress Note [28 visits covered from 12-09-09 through 03-03-10]
- o 03-05-10 Initial Adverse Determination letter
- o 03-10-10 Request for reconsideration from Dr.
- o 03-18-10 Adverse Determination letter on reconsideration

- o 03-25-10 Request for IRO from the Claimant
- o 03-26-10 Confirmation of Receipt of Request for IRO from TDI
- o 03-26-10 Notice of Case Assignment of IRO from TDI
- o 03-26-10 Letter of appeal from Dr.

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury to the low back and right knee on xx/xx/xx when he fell from a ladder. He is status post arthroscopic examination of the right knee with debridement and medial meniscal tear, arthroscopic lateral retinacular release, arthroscopic abrasion chondroplasty mediofemoral condyle on November 18, 2009 and is followed for continuing knee complaints.

Right knee MRI performed May 26, 2009 was given conclusion: 1. A small joint effusion and small popliteal cyst are present with no fractures or intra-articular loose body. 2. There is evidence Grade II injury of the ACL. 3. Evidence of lateral meniscal tear is identified as described with no medial meniscal tear demonstrated. X-rays of the same date revealed no evidence of fracture or dislocation. There is a slight narrowing of the joint space medially, associated with somewhat hypertrophic intercondyloid eminence. Small lateral osteophytes are also seen at the distal and of the femur and the proximal end of the tibia. No recent bone injury.

At consultation on June 24, 2009 the patient reported intermittent muscle spasms and increased pain with prolonged sitting, standing and walking. MRI has shown evidence of a grade II injury of the ACL and lateral meniscal tear. He can work modified duty and will be sent for an orthopedic consultation.

Orthopedic consultation of August 18, 2009 noted 9/10 low back pain radiating into the right thigh and right knee pain of 9/10 and giving way. He initially attended PT and re-initiated PT with his current provider who also sent him for a knee MRI. His knee is quite painful and he guards the knee on examination. There is visible effusion. There is medial and lateral joint line tenderness. There appears to be instability. Recommendation was for arthroscopy to address the meniscal tear and examine the ACL.

The patient returned to his medical provider on September 4, 2009. Right knee surgery was pending and he was taken off work for a month. On October 14, 2009 he was given an additional month off work, still pending a knee surgery.

Right knee arthroscopy was performed on November 18, 2009 with a post-operative diagnosis of medial meniscal tear, chondromalacia patella and chondromalacia medial femoral condyle. Procedures included debridement, lateral retinacular release and chondroplasty. At post-op visit of November 24, 2009 the patient reported pain of 6/10 and some difficulty walking with the crutches. He will return to his medical provider for an aggressive post-op PT program. He was advised on various home exercise stretching to increase his ROM.

On December 7, 2009 the patient was reported to be pending post-op PT. He is given a prescription for 12 sessions of post-operative PT and initiated PT on December 9, 2009.

The patient returned to his orthopedic surgeon on January 5, 2010. He is attending PT with some relief noted. He reports right knee pain of 6/10. He feels a lot of weakness and worries that it might give out. He has a 10-degree extension lag and 120 degrees of flexion. He was advised to wean off crutches and given some home exercises.

The patient was reassessed in PT on January 18, 2010. He reports pain of 9/10. He is using crutches. Swelling is noted. Extension lag is 5 degrees and flexion is to 105 degrees. Strength is 3/5. He has shown improvement with active post-op rehabilitation. He will be progressed to early stage of Phase II to improve active ranges of motion and strength. Active care is planned.

Medical report of January 27, 2010 notes persisting low back pain and muscular spasms. Mild tenderness is noted at the right knee and motion is restricted and painful in all ranges. The knee joint is stable. "The rest of the knee exam is essentially unremarkable." He is advised to continue his therapeutic regimen.

PT reassessment of February 9, 2010 notes right knee pain of 8-9/10 with guarding and mild swelling. There is tenderness at the joint. Flexion is to 100 degrees. Strength is 4-/5. He has improved with therapy. He will progress to Phase II, in which he will focus on AROM and strength. Treatment content will be primarily active with modalities to the knee.

The patient returned to his orthopedic surgeon on February 16, 2010. He has been participating in PT and notes slow improvement. He reports a pain level of 6/10. He has weaned himself off his crutches and is currently using a cane. He reports burning pain in his feet. He has a 10-degree extension lag and approximately 120 degrees of flexion with mild pain. There is no instability noted. Additional PT is recommended to increase ROM and quadriceps strength.

According to the PT progress note of March 1, 2010 the patient reports constant achy pain in the right knee described as 7/10. He is using a cane. The incisions are well healed. Swelling is noted and tenderness at the medial and lateral joint line. Flexion is to 110 degrees and strength is 3+/5. He has improved strength and ROM. He would benefit from additional PT. He will be progressed to Phase II of his active rehabilitation to increase ROM and strength.

28 Daily Progress Note [for treatment visits 12-9-09 to 03-03-10] have been submitted for review: Treatment content is essentially active but also includes myofascial release, icing and electrical muscle stimulation. At visit number 6 on December 28, 2009 the patient shows improved ability for weight shifts with less discomfort. At visit number 9 on January 7, 2010 the patient shows improved ability for quad set exercises. On January 22, 2010 at visit number 15 the patient shows improved ability

for SLR flexion exercises. At visit number 23 on February 23, 2010 the patient reports increased ability for walking longer distances with the help of a cane. He elicited good tolerance for passive knee extensions. At visit number 24 on February 25, 2010 the patient reports mild increased ability for weightbearing activities. He demonstrated increased tolerance for MAIs exercises. At visit number 28 on March 3, 2010 the patient stated mild improved ability for walking longer distances with less discomfort. Objectively, there is tenderness and restricted ROM and weakness. Swelling is noted. He ambulates with help of a cane.

Request for 12 additional sessions of PT was considered in review on March 5, 2010 with recommendation for non-certification. 17 pages of medical records were reviewed. Medications were not reported. He is status post right knee arthroscopy on November 18, 2009. An imaging report was not submitted but right knee MRI of 5/26/09 was cited as: A small joint effusion and small popliteal cyst are present with no fracture or intra-articular loose body; there is evidence of Grade II injury of the ACL. Evidence of lateral meniscal tear is identified with no medial meniscal tear demonstrated. X-ray of the right knee, 8/20/08 and the most recent on 5/26/09, official copy not submitted is cited: No evidence of fracture or dislocation. There is a slight narrowing of the joint space medially associated with somewhat hypertrophic intercondyloid eminence. Small lateral osteophytes are also seen at the distal end of the femur and the proximal end of the tibia. No recent bone injury. EMG showed irritation of bilateral S1 nerve roots. The patient has attended an unknown number of pre-operative sessions of PT without improvement and an unreported number of post-operative PT sessions without note of progress as well as unknown amount of chiropractic treatments, without improvement and an unknown number of massage therapy sessions, without improvement. During peer call provider stated the claimant has attended 20 sessions of PT post-op and still has problems. Additional PT is desired to increase ROM and strength. ODG supports 12 sessions of PT for the patient's diagnosis. The PT notes from 3-1-10 documented improved ROM and strength of the right knee after the previous therapy sessions; however, a comparison of the muscle strength grades between the 3-1-10 visit and 2-9-10 visit shows that muscle strength actually decreased from a 4-/5 (2-9-10) to a 3+/5 rating in the latest evaluation (3-1-10). The therapy goals in the latest visit were not documented to have established correlations between objective measures of progress with specific task-oriented variables, such that therapy, would achieve functional recovery and facilitate return to work. Compliance with HEP is not documented.

The provider responded with a letter requesting reconsideration dated March 10, 2010. The patient has not reached his pre-injury level and can still improve. He continues to have functional deficits and is improving with physical rehabilitation. He can continue physical rehabilitation, as this is the most effective and rapid means to overcome his functional deficits, achieve his pre-injury functional level, achieve clinical MMI, and return to work.

Request for reconsideration 12 additional sessions of PT was considered in review on March 18, 2010 with recommendation for non-certification. The patient has attended 23 sessions of post-operative PT to date. Diagnosis is tear of lateral cartilage or meniscus and sprain of the cruciate ligament of the knee. He has had arthroscopy on November 18, 2009 and two unclarified injections. Imaging findings are summarized (no official reports available). He may also have acute lumbar radiculopathy per EMG. The amount and response to PT, chiropractic treatment and massage therapy have not been clarified. A peer discussion was attempted but not realized. ODG recommends an increase in active regimen and decrease in passive regimen and a fading of treatment frequency; excessive use of passive care is not recommended. Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. The records document minimal improvement with 23 visits of post-op PT and some decline in strength in recent notes. Factors of delayed recovery should be identified and addressed before pursuing continued therapy that provides no complete benefit. Lastly, the number of requested visits on top of the previous therapy sessions is deemed in excess of the recommendation of the referenced guidelines. There are no exceptional factors noted. In peer discussion, the provider (provider's colleague?) concurred that the additional therapy is not necessary.

According to a letter from the provider dated March 26, 2010 the patient has not reached a plateau and can still demonstrate improvement of AROM, strength and tolerance and performance of standing, walking, squatting and stairs. He continues to have functional deficits and is improving with physical rehabilitation. Request is for appeal of denial for additional 12 sessions of physical rehabilitation.

Request was made for an IRO.

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

ODG: PT post-arthroscopy is recommended. There is 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. 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. Post-surgical (Meniscectomy and chondromalacia): 12 visits over 12 weeks.

The patient is status post right knee arthroscopy with debridement and medial meniscal tear, lateral retinacular release, abrasion chondroplasty of the mediofemoral condyle on November 18, 2009. On December 7, 2009 he was given a prescription for 12 sessions of post-operative PT. On January 5, 2010 he demonstrated a 10-degree extension lag and 120 degrees of flexion. On January 18, 2010 after completing 12 visits of PT, he has a pain level of 9/10, extension lag is 5 degrees and flexion is to 105 degrees, strength is 3/5. He has shown improvement with active post-op rehabilitation and will be progressed to early stage of Phase II to improve active ranges of motion and strength. On January 27, 2010 the physician noted, mild tenderness at the right knee and restricted and painful motion in all ranges. The knee joint is stable. "The rest of the knee exam is essentially unremarkable." PT reassessment of February 9, 2010 noted right knee pain of 8-9/10 with guarding and mild swelling, tenderness at the joint, flexion to 100 degrees and strength of 4-/5. He will be progressed to Phase II. He has had 20 visits at this point. No PT is provided during the period of 2-3-10 to 2-18-10. By February 16, 2010 he has weaned himself off the crutches and is using a cane. He has a 10-degree extension lag and approximately 120 degrees of flexion with mild pain with a stable knee. Additional PT is recommended to increase ROM and quadriceps strength. On March 1, 2010 flexion is to 110 degrees and strength is 3+/5. He will now be progressed to Phase II. At PT visit number 28 on March 3, 2010 the patient noted mild improved ability for walking longer distances with less discomfort. Objectively, there was tenderness and restricted ROM and weakness. Swelling was noted. He ambulates with help of a cane.

Rationale for first line denial noted no imaging reports were submitted, however, the cited imaging reports were performed prior to the patient's arthroscopy and would not be particularly relevant. The amount of PT was unknown at that time. It was indicated that the patient had also attended chiropractic treatment and massage, but those treatments appear to have also been provided prior to his arthroscopy. In the peer discussion the provider stated the claimant had attended 20 sessions of PT post-op and still has problems. However, it is noted here that the number of post-op PT visits was actually 28 at that time. The first-line reviewer pointed out that muscle strength appeared to have decreased based on the examinations of 2-9-10 and 3-1-10 from 4-/5 to 3+/5. Unfortunately, the daily PT treatment notes do not document ranges of motion and/or strength quantitatively for a better assessment of strength over time, as strength can vary from hour to hour based on pain and examiner variability. However, this situation does not support improvement with PT and as noted, compliance with HEP is not documented.

Rationale for second line denial noted the amount and response to PT, chiropractic treatment and massage therapy have not been clarified. While the patient also has a lumbar injury and is being assessed for possible radiculopathy, I do not find any reports describing chiropractic treatment and massage. The patient may be also under chiropractic care for his low back condition, but this is not clarified in the reports and is not relevant to his knee treatment. Per the second-line reviewer, ODG recommends an increase in active regimen and decrease in passive regimen and a fading of treatment frequency; excessive use of passive care is not recommended. The treatment has been mostly active and the provider is seeking to progress the patient to a more aggressive active phase of treatment. Compliance with HEP has not been reported and exceptional factors for treatment beyond guidelines notes essentially continuing motion and strength deficits. In peer discussion, a colleague of the provider concurred that additional therapy is not necessary.

The patient is four months post surgery and approximately 12 weeks post initiation of PT. The patient was noted at the time of arthroscopy to have "some mild lateral patellar subluxation." and a lateral retinacular release was performed along with the other procedures. References indicate 6-12 weeks of rehabilitation following retinacular release would be the norm. Given the number of PT visits already provided, and the ability of the patient to now participate in active exercises which can be performed through a structured HEP, additional formal PT beyond the amount recommended by the guidelines is not supported.

Therefore, my recommendation is to agree with the previous non-certification for 12 additional sessions of physical rehabilitation.

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

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 Chapter (3-26-2010) Physical Therapy:

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.

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.

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

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

## POSTOPERATIVE REHABILITATION

### Lateral Retinacular Release

The following is a general guideline for the rehabilitation after lateral retinacular release.

Advancement of the patient to the next phase should be considered on an individual basis taking also into consideration the surgeon's directives. The overall goal of rehabilitation is to reestablish appropriate extensor mechanism function and reduce patellofemoral contact forces.

Phase I: Immediate Postoperative - Weeks 1-2

Goals: Control postoperative pain and swelling

Protect tissues in the process of healing limiting range of motion  
Improve muscle function of the lower extremity, specially quadriceps and VMO  
Improve range of motion: 0°- 115° knee flexion and full knee extension  
Full weight bearing if extension ROM is controlled by muscle  
Independent ambulation

Intervention:

- Pain, inflammation and hemarthrosis management: Cryotherapy, compression bandage, elevation and ankle pumps
- ROM: Early range of motion is needed to ensure that the lateral structures are maintained in an opened or released position.
- Knee flexion: 0-1 week: 0°- 90° flexion, 75° by day 3, 110°-115° by week 2.
- Knee extension: full.
- Brace: 0-2/4 wks - locked in full extension, removed for rehabilitation
- Some do not recommend the use of immobilizers
- Weight bearing: immediate post-operative ambulation with crutches, weight bearing as tolerated (WBAT). Full by 2 weeks
- Therapeutic Exercise:

Quadriceps sets at full extension progressing to multi angle isometrics

Electrical stimulation for VMO

Hip external rotators strengthening

Heel slides and wall slides

Non-weight bearing gastrocnemius/soleus, hamstring, ITB, hip flexors stretching

4-way SLR with brace locked in full extension.

- Begin abduction at approximately 3 weeks to minimize lateral pulling of this muscle group on the patella.

Patellar mobilization (when tolerable)

Aquatic therapy at 2 wks (when wound is healed) with emphasis on gait training

Stationary bike for ROM when sufficient knee flexion is achieved

Phase II - Weeks 3-5

Criteria for progression: Well-controlled swelling and pain

Good quadriceps strength and control

ROM: 90° of active knee flexion and full active knee extension

Full weight bearing

Goals: Increase lower extremity strength and flexibility: 70% muscle reconditioning

Control of quadriceps and VMO for proper patellar tracking

Exercise swelling controlled

Improve gait pattern, balance and proprioception.

Establish home exercise program

Independent activities of daily living

Intervention:

- Brace: if brace is used, discontinue use for sleeping, brace at 0°-60° when ambulating
- Weight bearing: WBAT without crutches if:
  - Full active knee extension, active 90°- 100° knee flexion, non-antalgic gait pattern, and no extension lag with SLR.
  - Patient can progress from two to one crutches, and then ambulate without them.
- ROM: Knee flexion: Week 2: 100°-115°

Week 3: 115-125°

Knee extension: 60°-0°

- Therapeutic Exercise:

45° flexion with heel slides

Complete lower extremity flexibility: Quadriceps, ITB and hip flexors stretching and progress to weight-bearing gastrocnemius/soleus stretching

Calf raises

4 way hip exercises

Wall slides progression (0-45°) to mini squats

Closed chain kinetic terminal knee extension with resistive tubing or weight machine, and open chain reconditioning.

Balance and proprioceptive activities

Stationary bike

Treadmill walking with emphasis on normalization of gait pattern

Aquatic therapy

Aerobic reconditioning

Phase III Week 6 weeks return to activity

Criteria for progression: Good to Normal quadriceps strength

Non-antalgic gait

No evidence of lateral patellar tracking or instability

Pain is controlled and associated with activity only

Clearance from physician to progress closed-chain exercises and resume full or partial activity

Necessary joint range of motion, muscle strength, and endurance to safely return to athletic participation

Knee extension: 70% of contralateral side.

Goals: Restore any residual loss of ROM

Improve functional strength and proprioception

Return to appropriate activity level

Maintenance program development

Intervention:

- Brace: for activity only

- Therapeutic Exercise:

Endurance - swimming, stairmaster

Complete lower extremity flexibility

Continue balance activities and gait training

Progression of closed-kinetic chain exercises and proprioception exercises

Step-ups - 2 inches progress to 8 inches: forward and lateral

Stationary bike - moderate resistance

Leg press 0-45 degrees of flexion

0-70° wall squats

Knee extension 90-0°

Toe raises, hamstring curls

Jogging/running in pool with resistance

-Walk/jog progression, Jogging in pool with progression to land

- Forward and backward running, cutting, figure 8's

Slide Board

Plyometrics

Emphasis on sport/work -specific activity development

Return to sports when the knee is pain free, near full ROM has been obtained, and they have achieved at least 80% strength as compared with the opposite leg. Most patients are able to go back to sports by four to six months (Arendt, Fithian and Cohen 2002).

[[http://xnet.kp.org/socal\\_rehabspecialists/ptr\\_library/08KneeRegion/19Patella-LateralRetinacularRelease.pdf](http://xnet.kp.org/socal_rehabspecialists/ptr_library/08KneeRegion/19Patella-LateralRetinacularRelease.pdf)]