CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 8-18-10
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Physical therapy 3 x week x 4 weeks for the left knee 97014, 97140, 97110

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
American Board of Orthopaedic Surgery-Board Certified

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
- 5-1910 Surgery performed by Dr..
- Physical therapy on 5-21-10, 5-24-10, 5-26-10, 5-28-10, 6-1-10, 6-2-10, 6-4-10, 6-7-10, 6-9-0, 6-11-10.
- 6-17-10, DO., performed a Utilization Review.
- Physical therapy discharge on 6-24-10. The claimant underwent 12 sessions from 5-21-10 through 6-16-10.
- 6-29-10, MD., office visit.
- 7-12-10, MD., performed a Utilization Review.
- 7-20-10, PAC., office visit.

PATIENT CLINICAL HISTORY [SUMMARY]:
5-19-10 Surgery performed by Dr.: Left knee arthroscopy, partial medical meniscectomy, debridement arthrofibrosis, thermal chondroplasty patella, arthoscopic lateral release.
Physical therapy on 5-21-10, 5-24-10, 5-26-10, 5-28-10, 6-1-10, 6-2-10, 6-4-10, 6-7-10, 6-9-0, 6-11-10.

6-24-10 discharge note. The claimant's range of motion in the left knee is 2-95 degrees. MMT is 3+/5 at quad, ham, and within current range. Goals for range of motion, decreasing pain and reported strength are not met. Additional treatment request have been denied.

6-17-10, DO., performed a Utilization Review. Internal nurse notes state that the patient has completed 10 postoperative physical therapy sessions to date. Established guidelines recommend a maximum of 12 visits over 12 weeks for the diagnosis of status post meniscectomy. There does not appear to be any exceptional factors that would warrant continued physical therapy beyond what Official Disability Guidelines recommend. It appears as though this patient has plateaued as she has not made significant progress from 06/01/2010 to 06/11/2010. There is no comprehensive physical examination submitted for review that demonstrates a persisting functional deficit that would reasonably improve with continued formal physical therapy beyond what the guidelines recommend. There should be a decrease in treatment frequency over the duration of physical therapy as the patient should be transitioned to a home exercise program in order to continue to facilitate improvement. Additionally, the modalities 97035 and 97014 are passive modalities and not commonly supported or recommended by Official Disability Guidelines. As such, this request is non-certified at this time.

Physical therapy discharge on 6-24-10. The claimant underwent 12 sessions from 5-21-10 through 6-16-10.

6-29-10, MD., the claimant is seen for follow up of her left knee arthoscopy with partial medial meniscectomy, debridement for arthrofibrosis, thermal chondroplasty of the patella and arthroscopic lateral release. She continues to make slow progress but had physical therapy denied. She his pain, weakness and difficulty ambulating. The evaluator reported the claimant clearly needs additional therapy due to the complex nature of her knee problem and delay in receiving surgical care. She was given samples and prescriptions for Voltaren gel.

7-12-10, MD., performed a Utilization Review. The patient sustained injury ors. x/xx/xx. She has undergone left knee arthroscopy and medial meniscectomy on 05/19/10. As per medical report dated 6/29/10, patient continues to have stiffness, weakness and atrophy of the leg. Examination of the left knee revealed satisfactory patellofemoral tracking and mildly positive patellar compression, mild swelling, significant quadriceps atrophy and limited passive and active ROM due to pain. This is an appeal for the requested additional 12 PT sessions. However, the patient has received a substantial number of physical therapy sessions and the addition of the requested number of visits exceeds the recommendations. If indeed the patient is not yet fully improved, factors prolonging or delaying recovery should be identified and addressed rather than pursuing a continued therapy that provides no complete benefit. Considering the date of surgery, this patient should have fully progressed into an independent exercise program. There was no mention why a home exercise program would not be sufficient in addressing any remaining deficits. The medical necessity of this request is not fully established at this

time. Determination: The request is not certified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for physical therapy of the left knee for three times a week for four weeks 97014 97140 97110 is not medically necessary.

7-20-10, PAC., the claimant comes in today and had questions about her recovery. He discussed with the case manager that the claimant does need approximately three months of physical therapy for quad strengthening.

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

Claimant sustained injury to the left knee and underwent surgery on 05/19/10 with an arthroscopy, medial meniscectomy, chondroplasty and lateral release.

Claimant had 12 postoperative physical therapy visits. Per the ODG treatment guidelines, 12 postoperative physical therapy visits would be medically appropriate. The medical records do not reflect the indication for additional physical therapy as requested by the treating physician.

The surgical procedures performed on the left knee are common and not unusual. With a lack of documentation to support the necessity of additional therapy, the request for additional physical therapy 3 x 4 is not reasonable at this juncture.

ODG-TWC, last update 8-5-10 Occupational Disorders of the Knee – 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. (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) 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) This RCT concluded that, after primary total knee arthroplasty, an outpatient physical therapy group achieved a greater range of knee motion than those without, but this was not statistically significant. (Mockford, 2008) See also specific physical therapy modalities by name, as well as Exercise.

Active Treatment versus Passive Modalities: See the Low Back Chapter for more information. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530).

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
Pain in joint; Effusion of joint (ICD9 719.0; 719.4):
9 visits over 8 weeks
Arthritis (Arthropathy, unspecified) (ICD9 716.9):
Medical treatment: 9 visits over 8 weeks
Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment, arthroplasty, knee: 24 visits over 10 weeks
Abnormality of gait (ICD9 781.2):
16-52 visits over 8-16 weeks (Depends on source of problem)
Fracture of neck of femur (ICD9 820):
Post-surgical: 18 visits over 8 weeks
Fracture of other and unspecified parts of femur (ICD9 821):
Post-surgical: 30 visits over 12 weeks
Fracture of patella (ICD9 822):
Post-surgical: 10 visits over 8 weeks
Fracture of tibia and fibula (ICD9 823)
Medical treatment: 30 visits over 12 weeks
Post-surgical treatment (ORIF): 30 visits over 12 weeks
Amputation of leg (ICD9 897):
Post-replantation surgery: 48 visits over 26 weeks
Work conditioning
See Work conditioning, work hardening

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**