

## Notice of Independent Review Decision



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### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical Therapy 3 x Week x 4 Weeks

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

Certified by the American Board of Orthopaedic Surgery

### **REVIEW OUTCOME**

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

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	836	97110	
		Prospective	836	97140	

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization. Progress notes dated 5/4/09, 5/27/09, 6/24/09, 7/22/09, 8/26/09, 9/23/09, 10/21/09, 11/18/09, 12/16/09

Evaluation dated 12/8/09

Operative Summary/Report dated 9/17/09

X-ray report dated 4/7/09

Physical Therapy progress sheet/evaluation/notes dated 3/30/09, 4/1/09, 4/6/09, 10/5/09, 10/12/09, 10/26/09, 10/27/09, 10/29/09

Official Disability Guidelines provided-ODG Treatment Knee & Leg (Acute & Chronic)  
Knee-Physical medicine treatment

### **PATIENT CLINICAL HISTORY:**

The patient is a 51-year-old male who is reported to have sustained an injury to his right knee as the result of a slip and fall at work on 03/05/09. Records indicate that the patient apparently received at least 6 sessions of physical therapy. The patient was subsequently referred for MRI of the right knee on 04/07/09. This study reports ferromagnetic artifact in the medial compartment of the knee joint from partial replacement of the medial compartment of the knee joint with associated ferromagnetic artifact. There is no tear identified within the lateral meniscus. The lateral collateral ligaments as well as the popliteal tendon are seen without abnormalities. There is no bony contusion or cortical disruption. There is patella alta with lateral tilt with a small subchondral erosion on the superior third

of the patella measuring 3.3 mm in widest diameter. The remainder of the tendinous and ligamentous structures is unremarkable. There is an incidental note of a lateral suprapatellar plica.

On 05/04/09 the patient was seen. At this time the patient complains of right knee pain. He is status post fall at work on 03/05/09. The physician reports he has previously treated this patient for his right knee. He underwent a medial compartment hemiarthroplasty and was doing very well until his injury. He has been treated with some therapy and has undergone MRI of the knee which revealed a chondral injury to the patella. The patient reports still having some pain with walking, going up and down the stairs and kneeling. On physical examination he has a healed incision from his previous surgery and range of motion is 0-125. There is no medial or lateral instability. There is no effusion and he has some slight tenderness along the medial epicondyle and also infrapatellarly. He has negative Lachman's test. Radiographs reveal well placed hemiarthroplasty in good position with no evidence of loosening. The patient subsequently was recommended to receive a corticosteroid injection which was provided at this visit.

The patient was seen in follow up on 05/27/09. He continues to have discomfort in the knee and the injection is reported to help. He has no obvious effusion. He has tenderness infrapatellarly. He has pain with compression of the patellofemoral joint. The patient subsequently received a second corticosteroid injection at this visit.

The patient was seen in follow up on 06/24/09. At this time, it is reported that the patient complains of weakness in his knee and difficulty when he tries to get up from a chair. On physical examination there is some atrophy of the vastus medialis obliquus. He has some tenderness infrapatellarly and there is no obvious effusion or instability. Range of motion is 0-125. The patient is reported to have not received therapy yet and it is recommended that he obtain this so that he can strengthen his knee.

The patient was seen in follow up on 07/22/09. It is reported that the patient has not received physical therapy and he is still experiencing some pain in the knee. On examination there is tenderness along the medial patellar facet. He has some vastus medialis obliquus atrophy. There is tenderness along the patellar tendon. The patient is strongly recommended to undergo physical therapy.

The patient was seen in follow up on 08/26/09. He is reported to have not undergone any therapy. The patient's physical examination is unchanged. The patient subsequently is recommended to undergo arthroscopic surgery.

On 09/17/09 the patient was taken to surgery and subsequently underwent a comprehensive arthroscopy, chondroplasty and a lateral release of the right knee.

On 09/23/09 the patient was seen in post operative follow up. The stitches were removed, Steri strips were applied and there was some post operative swelling. The patient was subsequently referred for physical therapy.

On 10/05/09 the patient underwent physical therapy evaluation. He subsequently is recommended to undergo physical therapy 3x wk x4 wks.

On 10/12/09 it is reported that the patient has completed 4/12 physical therapy sessions. His range of motion is increasing however progress is limited somewhat by low back pain.

On 10/21/09 the patient was seen in follow up. It is reported that the patient is making improvement. He has some slight tenderness along the lateral patellar region and there is no obvious effusion. He has

decreased quadriceps tone. Range of motion is 0-125. He is recommended to continue in physical therapy.

On 11/18/09 the patient was seen in follow up. He is reported to have not gotten any therapy yet and is reported to have atrophy of the quadriceps. Range of motion is 0-125 and he has some tenderness infrapatellarly.

On 12/08/09 the patient underwent a medical examination. It is noted that the patient has multiple complaints including back, bilateral knee, calf, heel and right thigh pain. Examinee reports pain with weight bearing. He does walk on a bent knee. He reports a popping and grinding in the bone. He reports his knee swells at times. On physical examination the patient is 5'8" tall and weighs 204 pounds. There is no swelling or effusion and apprehension test was positive on the right. There is medial joint line tenderness but no lateral joint line tenderness. He has a negative anterior and posterior drawer sign. There was negative McMurray's and Apley's test. Pivot shift test is negative. Range of motion of the right knee is -5-110. Range of motion of the left knee is 0-145. Muscle strength is graded 4+/5 in the hamstrings. Thigh measurements are 44 cm bilaterally and calf is 40 cm on the right at 39 cm on the left. The patient was opined to not be at MMI. He is reported to have had only 4 weeks of physical therapy and it is opined he would benefit from an additional 4-6 weeks.

The patient was seen in follow up on 12/16/09. At this time, it is reported that the patient still has some discomfort in his knee. He is reported to have atrophy of the quadriceps, weakness of the vastus medialis obliquus. Range of motion is 0-130 and he has some tenderness infrapatellarly.

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

In the Reviewer's opinion, the request for physical therapy 3x4 (or 12 sessions) is not deemed medically necessary. The submitted clinical records indicate that the patient sustained an injury to his right knee as a result of slip and fall. Records indicate that the patient underwent at least 6 sessions of pre operative physical therapy. He subsequently was taken to surgery on 09/17/09 and underwent chondroplasty and a lateral release. Based on the patient's diagnosis, the Official Disability Guidelines would have supported up to 12 sessions of post operative physical therapy. Records indicate that the patient completed these 12 sessions. The records suggest that the patient has subjective reports of pain however an independent physical examination performed on 12/08/09 shows no evidence of quadriceps atrophy and the patient is noted to have reduced range of motion however this is also consistent with his history of hemiarthroplasty. The Reviewer noted that the submitted physical therapy records do not provide detailed functional goals or assessments as to the patient's progress toward achieving these goals. The record does not provide any data that would indicate that the patient would be incapable of performing a daily, self directed home exercise program. Based upon the totality of the clinical information, the request for additional physical therapy 3x4 is not supported as medically necessary and exceeds current evidence based guidelines.

#### **REFERENCES:**

The 2010 Official Disability Guidelines, 15th edition, The Work Loss Data Institute. Online edition. 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 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.

### **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

**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)