

# Prime 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/24/2010

**IRO CASE #:**

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

Outpatient physical therapy (PT) to the bilateral knees for twelve (12) sessions to consist of therapeutic exercise neuromuscular reeducation and manual therapy not to exceed 4 units per session

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training in Physical Medicine and Rehabilitation and Orthopedic Surgery

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 3/16/10, 4/5/10

Clinic 5/5/10, 3/26/10, 3/10/10

Medical Centers 5/22/09, 6/11/09, 3/1/10

Spine 2/26/10

M.D. 3/10/10

M.D. 3/11/10, 3/30/10

Churchill 10/2/09

M.D. 4/20/10

ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This patient fell on xx/xx/xx and developed low back pain. She subsequently had a hemilaminectomy and discectomy on 10/22/09 followed by 16 visits of post op therapy for her back. Although the records note the patient fell on her knees and hands at the time of the injury, the medical records did not describe significant knee pain until Dr. saw her on 3/10/10. He noted bilateral knee pain. He wrote that " There is some mild tenderness to palpation.

There is occasional crepitation noted. The knee joints are stable. There is decreased range of motion to flexion with normal extension, and the balance of the bilateral knee exams is essentially unremarkable." His diagnosis was a contusion and possible internal derangement. He wrote on 5/5/10 that her progress had not plateaued and he wanted more aggressive rehab.

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

While the records predominately discussed treatment of this patient's back, this request is for physical therapy for the knees. The records note bilateral knee pain. Dr. wrote that "There is some mild tenderness to palpation. There is occasional crepitation noted. The knee joints are stable. There is decreased range of motion to flexion with normal extension, and the balance of the bilateral knee exams is essentially unremarkable." His diagnosis was a contusion and possible internal derangement. The ODG recognizes the role of specialized therapy for patellofemoral pain syndrome. For comparison, a patella fracture is allowed 10 therapy sessions over 8 weeks. Knee arthritis, not necessarily chondromalacia or retropatella syndrome, would allow 9 sessions over 8 weeks. The ODG states that the "use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes." While this request is for 12 visits, the reviewer agrees with the treating physician that the patient would benefit from active rehabilitation therapy. The reviewer finds that medical necessity exists for Outpatient physical therapy (PT) to the bilateral knees for twelve (12) sessions to consist of therapeutic exercise neuromuscular reeducation and manual therapy not to exceed 4 units per session.

#### 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) 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

Non-surgical intervention for PFPS (patellofemoral pain syndrome)

Recommend specific exercises aimed at realignment of the patella rather than interventions just addressing short-term relief of symptoms. A supervised exercise program for patellofemoral pain syndrome (PFPS) more effectively improves pain and function than usual care emphasizing rest and activity avoidance, according to a recent RCT. The treatment intervention included exercises for quadriceps strengthening, flexibility, balance, and coordination, progressively increasing in complexity over time. (Van Linschoten, 2009) A common treatment for patients with PFPS is strength training of the vastus medialis oblique muscle. Hip adduction in conjunction with knee extension is commonly used in clinical practice; however, evidence supporting the efficacy of this exercise is lacking. This RCT randomly assigned patients to 1 of 3 groups: hip adduction combined with leg-press exercise, leg-press exercise only, or no exercise (control group). Significant improvements were observed after the intervention in both exercise groups, but not in the control group, and incorporating hip adduction with leg-press exercise had no impact on outcome in patients with PFPS. (Song, 2009)

The evidence to support the use of some physical interventions in the management of PFPS has been limited. There appears to be a consistent improvement in short-term pain and function due to physical therapy treatment, but comparison with a placebo group is required to determine efficacy, and further trials are warranted for the other interventions. (Crossley, 2001) One meta-analysis analyzed five trials that compared the effectiveness of knee or foot orthotics for the treatment of PFPS, but concluded that the evidence from randomized controlled trials is currently too limited to draw definitive conclusions about the use of knee and foot orthotics for PFPS. (D'hondt-Cochrane, 2002) While foot orthoses are superior to flat inserts according to participants' overall perception, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. Given the long-term improvement observed in all treatment groups, general practitioners may seek to hasten recovery by prescribing prefabricated orthoses. (Collins, 2008)

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

ACOEM-AMERICA 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)