



Medical Review Institute of America, Inc.
America's External Review Network

Amended Review 5/3/10 & 5/12/10

DATE OF REVIEW: April 30, 2010

IRO Case #:

Description of the services in dispute:

1. 12 sessions of physical rehabilitation.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician reviewer providing this review is board certified by American Board of Physical Medicine and Rehabilitation in Physical Medicine and Rehabilitation. This reviewer has additional training in Hyperbaric Medicine and Acupuncture. This reviewer has been in active practice since 1993.

Review Outcome

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

Upheld

Continued physical therapy treatment will have no considerable benefit to the patient. Therefore, the medical necessity for the request has not been established and is not recommended at this time.

Information provided to the IRO for review

Records from the State:

- Notice of Assignment of IRO 4/20/10 (3 pages)
- Request for A Review of IRO 4/15/10 (10 pages)
- Review Outcome 4/5/10 (2 pages)
- Review Outcome 3/8/10 (2 pages)
- Letter 4/22/10 (1 page)
- Letter MD 4/20/10 (1 pages)
- Orthopedic Report 4/12/10 (3 pages)
- Office Notes 4/12/10 (3 pages)

Diagnosics Note 4/12/10 (1 page)
Work Status Report 4/12/10 (1 page)
Work Status Report 1/18/10 (1 page)
Request for Authorization 3/29/10 (1 page)
Request for Reconsideration 3/26/10 (2 pages)
Orthopedic Report 3/25/10 (2 pages)
Work Status Report 3/25/10 (1 page)
Office Notes 3/25/10 (3 pages)
Diagnosics Note 3/25/10 (1 page)
Consultation Report 3/19/10 (2 pages)
Work Status Report 3/19/10 (1 page)
Fitting and Patient Acceptance Form 3/8/10 (1 page)
Consent 3/8/10 (1 page)
EMS Prescription and Statement of Medical Necessity 3/8/10 (3 pages)
Request for Authorization 3/3/10 (1 page)
Physical therapy Evaluation 2/26/10 (2 pages)
Work Status Report 12/31/09 (1 page)
Work Status Report 12/30/09 (1 page)
Office Notes 2/19/10 (1 page)
Office Notes 2/17/10 (1 page)
Work Status Report 2/16/10 (1 page)
Allied Diagnostic Note 2/16/10 (1 page)
Office Notes 2/16/10 (3 pages)
Orthopedic Consult 2/16/10 (3 pages)
Work Status Report 1/11/10 (1 page)
Office Notes 2/15/10 (1 page)
Office Notes 2/12/10 (1 page)
Work Status Report 2/10/10 (1 page)
Consultation Report 2/10/10 (2 pages)
Office Notes 2/10/10 (1 page)
Office Notes 2/9/10 (1 page)
Office Notes 2/4/10 (1 page)
Office Notes 2/3/10 (1 page)
Office Notes 2/1/10 (1 page)
Office Notes 1/29/10 (1 page)
Initial Evaluation 1/27/10 (3 pages)
Work Status Report 1/27/10 (1 page)
Work Status Report 1/18/10 (1 page)
Physician Activity Status Report 12/24/09 (1 page)
Orthopedic Clinic Note 1/18/10 (1 page)
Work Status Report 1/11/10 (1 page)
ODG Return to Work Summary Guidelines (5 pages)

Peer Review/Medical Record Review Disclaimer (1 page)
Peer Review 1/12/10 (4 pages)
Physician Activity Status Report 1/18/10
Orthopedic Clinic Note 1/11/10 (1 page)
Work Status Report 1/11/10 (1 page)
Work Status Report 1/4/10 (2 pages)
Progress Notes 12/31/09 (1 page)
Physician Activity Status Report 12/24/09 (1 page)
Work Status Report 12/31/09 (1 page)
Progress Notes 12/30/09 (1 page)
MRI Left Knee 12/30/09 (2 pages)
Work Status Report 12/24/09 (1 page)
Work Status Report 12/24/09 (1 page)
Medical Center Facesheet
Emergency Room Records 12/24/09 (2 pages)
Orders (2 pages)
Radiology Report 12/24/09 (3 pages)
Prescription 12/24/09 (1 page)
Physician Activity Status Report 12/24/09 (1 page)
Office Notes 12/24/09 (2 pages)
Physician Activity Status Report 1/4/10 (1 page)
Orthopedic Clinic Note 1/4/10 (1 page)
Supplemental Report of Injury 12/24/09 (1 page)
ED Patient Record 12/24/09 (21 pages)
X-ray Knee 12/24/09 (2 pages)
Employer's First Report of Injury or Illness xx/xx/xx
Independent Review Organization Summary (2 pages)

Patient clinical history [summary]

The patient is a male who was injured on xx/xx/xx due to a fall. An emergency room note dated xx/xx/xx/reports patient complaints of low back and left knee pain. The radiograph reports of the lumbar spine and left knee dated xx/xx/xx reveals a normal lumbar spine and the left knee has no fracture or dislocation with mild osteoarthritis. The patient was treated with the application of an Ace wrap to the left knee and crutches, also a prescription for Motrin, Darvocet, and Flexeril. A clinical note dated xx/xx/xx reports patient complaints of low back and left knee pain. The exam reveals decreased lumbar range of motion with spasms. The left knee displays mild swelling with minimal ecchymosis and tenderness over the medial joint line. The patient has an antalgic gait. A clinical note dated 12/30/09 reports patient complains of the same as the prior. The exam reveals tenderness L3-L5 with limited range of motion. The left knee displays tenderness along the medial joint line and posterior lateral aspect with flexion to 60 degrees and the patient's gait is antalgic. A left knee MRI report dated 12/30/09 reveals a complex tear the posterior horn of the medial meniscus, with horizontal oblique component extending to the superior and inferior articular

surfaces and probably also to the posterior peripheral margin. Grade 1 or mild grade 2 sprain of the medial collateral ligament. There is diffuse thinning of cartilage overlying the weight-bearing surface of the medial femoral condyle and overlying the medial patellar facet, suggesting grade 2/3 chondromalacia. There is a 7 mm focus of marrow edema with subcortical cyst formation in the lateral tibial plateau, located anteriorly and centrally. This may represent a focus grade 4 chondromalacia. Small to moderate joint effusion. A clinical note dated 12/31/09 reports the patient received results of the left knee MRI. The clinical notes dated 1/4/10, 1/11/10 and 1/18/10 reports the patient attended followup appointments with no change to symptoms or exam. A clinical note dated 1/27/10 reports the patient complains of cervical, thoracic, and lumbosacral spine pain as well as left knee pain and locking. The exam reveals decreased range of motion throughout the cervical to lumbar spine. There is tenderness throughout the thoracic and lumbosacral regions. The left knee displays pain and decreased range of motion to flexion and extension. A clinical note dated 2/10/10 reports the patient complaints and the exam was the same as the prior. The patient has been recommended for orthopedic consultation. A clinical note dated 2/16/10 reports the patient complains of left knee pain 8/10 with occasional popping, locking, swelling and giving way and low back pain rated at 6/10 which radiates to lower extremities with occasional numbness and tingling to the feet. The left knee reveals decreased range of motion with a 10 degrees extension lag to about 90 degrees of flexion, 2+ effusion, positive McMurray's, and pain with varus and valgus stress. The lumbar exam reveals decreased range of motion and tenderness. With regards to the patient's knee, the patient has exhausted all reasonable non-operative treatment. The recommendation is for an arthroscopy. The therapy notes dated 1/29/10 and 2/19/10 report the patient received 10 treatments for neck pain. A therapy evaluation dated 2/26/10 reports patient complains of knee pain 8/10. The exam reveals swelling and tenderness over the medial joint line, extension -20 degrees, flexion 100 degrees and strength are flexion 3/5 and extension 3-/5. A clinical note dated 3/25/10 reports continued knee pain with the exam revealing decreased range of motion and decreased range of motion and pain to the lumbar spine. The recommendation is for left knee arthroscopy. The clinical notes dated 4/12/10 and 4/20/10 are provided as letters of medical necessity to indicate the patient's history, diagnostic studies, and need for further physical therapy.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The clinical information provided for this review reports the patient was referred for physical therapy for 6 sessions on 12/29/09 and 1/27/10 for a total of 12 sessions of treatment. A clinical note dated 2/16/10 reports, and the plan of treatment, the patient has exhausted all reasonable non-operative treatment, including trying physical therapy and medications with oral anti-inflammatories, without relief. The patient continues to be symptomatic and has pain in his knee in a sitting position as well as patellar movements; the exam note goes on to recommend a left knee arthroscopy. The submitted physical therapy treatment notes dated 1/29/10-2/19/10 report the patient was treated for cervical pain; however, the referrals are noted to have been for lumbar and knee strain. The treatment notes for the left knee have not been submitted for this review. Also, it is reasonable to believe, as the exam note reports the patient has exhausted conservative treatment

efforts with continued significant objective functional deficits; then continued physical therapy treatment will have no considerable benefit to the patient. Therefore, the medical necessity for the request has not been established.

A description and the source of the screening criteria or other clinical basis used to make the decision:

ODG, online edition

Chapter: Knee & Leg

ODG Physical Therapy 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.

There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.

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