



Notice of Independent Review Decision-WC
CLAIMS EVAL REVIEWER REPORT - WC



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

DATE OF REVIEW: 4-13-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 sessions of physical therapy to the left knee

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

Chiropractor

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

PATIENT CLINICAL HISTORY [SUMMARY]:

5-6-05 MRI of the left knee shows small intra articular effusion. There is a horizontal cleavage tear of the posterior horn of the lateral meniscus extending through the inferior articular surface a horizontal tear involving the superior articular surface of the anterior horn of the lateral meniscus is also seen. Grade IV chondromalacia of the lateral

posterior patellar facet with focal disruption of the cortex just lateral to midline with juxtacortical cyst formation.

5-6-05 MRI of the right knee showed no anatomical abnormality can be identified.

On 9-14-05, an EMG/NCS performed by MD., showed left L5 radiculopathy.

5-29-07 MD., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI with a 6% impairment rating based on Table 64 for 1% and 5% under DRE UU for the lumbosacral spine, for a total of 6% whole person.

11-10-10 MRI of the left knee showed meniscal tear extends the superior and inferior articular surface and inner free edge of the anterior and posterior horn and mid body of the lateral meniscus extending to its root. Meniscal tear extends to the inferior articular surface of the posterior horn of the medial meniscus. Moderate to severe tricompartmental osteoarthritic changes. Moderate sized joint effusion, trace amount of fluid in the pes anserinus bursa and popliteal recess, diffuse synovitis within the knee with multiple sub centimeter intra articular bodies and debris.

1-13-11 Surgery performed by MD: arthroscopic examination of the left knee. Partial medial meniscectomy to the left knee, partial lateral meniscectomy to the left knee, removal of chondral loose bodies greater than 5mm on the left knee, arthroscopic debridement to the medial femoral condyle, medial tibial plateau and patellofemoral joint of the left knee under arthroscopic control, major synovectomy medial compartment, lateral compartment of the left knee.

1-20-11 MD., the claimant had arthroscopic surgery on her left knee on 01/13/11. Today her left knee looks good. On examination of the left knee, the sutures were removed. The wounds are clean and these areas were Steri-Stripped. A slight effusion is present. Range of motion is from -5 to 10 degrees of extension to about 90 degrees of flexion. There is minimal joint line tenderness. There is no ligamentous instability, no calf tenderness, a negative Homans' sign and a good distal pulse in the left lower extremity. Impression: Status post arthroscopic surgery, left knee. The evaluator refilled her pain pills and asked her to take these sparingly. She will go to physical therapy and will return in 10 days.

1-31-11 MD., the claimant had arthroscopic surgery on her left knee on 01/13/11. She has not started therapy yet and has been approved to start tomorrow, February 1, 2011. Physical examination of the left knee today reveals the effusion is down. Range of motion is still limited to about —5 degrees of extension to about 1.00 degrees of flexion. She still has minimal joint line tenderness. There is no apparent ligamentous instability, no calf tenderness, a negative Homans' sign and good distal pulses in the left lower extremity. The evaluator urged her to walk with a heel-toe gait. She is ambulatory with one crutch. She still has some giving way, which I suspect is due to her inability to completely straighten out or lock her knee in extension after heel strike in her gait cycle.

She will work very hard at exercising in therapy. She will work on getting her motion back and then strength and will return in three weeks.

2-21-11 MD., the claimant had arthroscopic surgery on her left knee on 01/13/11. She has just started physical therapy. Physical examination of the left knee reveals range of motion at complete extension to about 120 degrees of flexion. There is some mild medial joint line tenderness and some mild lateral joint line tenderness. McMurray's and reverse McMurray's tests are both negative. There is no ligamentous instability, no calf tenderness, a negative Humans' sign, and a good distal pulse in the left lower extremity. Her gait is much improved. She will continue working in therapy and will return in three weeks. She said the therapist had been a bit rough with her in stretching and some of the knee exercises actually hurt her back, so we will modify her exercise program not to hurt her back and she will return in three weeks.

3-10-11 DC., the claimant is here for a follow up examination. She has completed 12 sessions of physical rehabilitation for the right knee. She continues to experience moderate left knee pain, weakness, and sensations of her left knee "giving out on her. Due to moderate weakness in her left knee post-surgery, she has developed an abnormality and overcompensation in her gait, which has caused an increase in low back pain. Due to moderate low back pain, it has hindered her progression with the post-surgical rehabilitation for the left knee. She has been prescribed a knee-unloader brace, which has helped in improving her tolerance to the active exercises. The claimant has had previous surgery to her left knee back in 08/02/2005 for a left knee tear of the lateral meniscus, medial plica band, chondromalacia, and lateral compartment synovectomy with M.D. Recently, she underwent another surgical procedure with MD., in which she repaired a torn medial meniscus, torn lateral meniscus, removal of loose bodies greater than 5 mm, and major synovectomy of the medial and lateral compartment of the left knee. She also notes significant left knee pain. She continues to utilize the TENS unit and DME products that have been issued to her. On exam, anterior and posterior drawer tests were negative in the bilateral knees. Apley compression was positive in the bilateral knees for increased pain. Patellar grind test was positive on the right side. Straight leg raise test was positive at approximately 70 degrees on the left and 130 degrees on the right. Kemp test was positive bilaterally. Patrick and Yeoman Tests noted increased lumbosacral pain. Swelling noted in the left knee as a result of surgery. Plan: Due to the extenuating circumstance of having subsequent surgeries to the left knee, he was submitting for additional sessions of post-surgical physical rehabilitation as prescribed by her operating surgeon, Dr., to help improve strength and stability in the left knee, In order to prevent the patient from developing further abnormality in her gait Due to moderate weakness in her left leg In comparison to the right side, she has developed an overcompensation in her gait, causing increased low back pain. After completing the reexamination of Mrs., he was recommending the patient to continue post-operative rehabilitation program as referred by Dr.. ODG guidelines recommends anywhere from 16-52 sessions of physical rehabilitation for abnormality in her gait, depending on the source of her problem.

3-17-11 DC., performed a Utilization Review. The evaluator reported that injured worker is status post arthroscopy of the knee on 1/13/11 with partial medial and lateral meniscectomies without chondroplasty. Injured worker has completed 12 sessions of physical therapy post operative. The last clinical note from the orthopedic surgeon is dated 2/21/11 at which time the injured worker was told to continue physical therapy and follow-up in three weeks. There are no current physical exam findings from the orthopedic surgeon or recent evaluations that would justify the medical necessity for continued physical, therapy that exceeds the Official Disability Guidelines. Injured worker has completed Official Disability Guidelines recommended physical therapy following arthroscopy of the knee. The physician advisor completed peer to peer phone conversation with Dr. on 3/17/11 and attempted peer to peer phone conversation with on 3/17/11. They discussed case/clinical records and denial rationale.

3-24-11 DC., provided a reconsideration letter. "After review of the denial for additional sessions of active care, he respectfully disagree with the findings of the peer reviewer. Mrs. has undergone multiple surgeries for the same knee for the compensable injury. Due to the patient's age, the length of her injuries, and the severity of her injuries, the patient has not recovered as fast as she should according to ODG. However, the patient has made significant progress with improved knee strength and range of motion in the right knee. Her walking and standing tolerances are also improved. She obviously is under an extenuating circumstance and outside the ODG guidelines. ODG even states that the guidelines are a guide for normal circumstances and does not apply to everyone. There will be circumstances such as in the claimant's case that ODG does not apply. The claimant is here for a follow up examination. She has completed 12 sessions of physical rehabilitation for the right knee. She continues to experience moderate left knee pain, weakness, and sensations of her left knee giving out on her. Due to moderate weakness in her left knee post-surgery, she has developed an abnormality and overcompensation in her gait, which has caused an increase in low back pain. Due to moderate low back pain, it has hindered her progression with the post-surgical rehabilitation for the left knee. She has been prescribed a knee-unloader brace, which has helped in improving her tolerance to the active exercises. The claimant has had previous surgery to her left knee back in 08/02/2005 for a left knee tear of the lateral meniscus, medial plica band, chondromalacia, and lateral compartment synovitis with M.D. Recently, she underwent another surgical procedure with M.D., in which she repaired a torn medial meniscus, torn lateral meniscus, removal of loose bodies greater than 5 mm, and major synovectomy of the medial and lateral compartment of the left knee. She also notes significant left knee pain. She continues to utilize the TENS unit and DME products that have been issued to her. Dr. has recommended for her to continue on an active care program."

3-30-11 DO., performed a Utilization Review. The request for reconsideration contained no objective information substantiating need for additional formal physical therapy. The request referred to previous surgeries to the same knee and subjective complaints that would necessitate exceeding Official Disability Guidelines criteria. However, progress note from Dr. of 2/1/11 documented excellent range of motion (120-0). It is not evident

why at this point a home exercise plan would not be indicated. The physician advisor completed peer to peer phone conversation with Dr. on 3-29-11.

3-31-11 MD., the claimant had arthroscopic surgery on her left knee on 01/13/11. She only had about 10-12 sessions of physical therapy and then they stopped it. Physical examination today reveals that her left knee is doing better. She has obvious quadriceps atrophy with a smaller thigh on the left than the right. Range of motion is at 0 degrees extension to about 125-130 degrees of flexion. There is mild medial and lateral joint line tenderness. There is no ligamentous instability, no calf tenderness, a negative Homans' sign, and a good distal pulse in the left lower extremity. Impression: Status post arthroscopic surgery, left knee. Disposition: She will continue exercising in therapy and will return for re-evaluation in four weeks. He felt it is ridiculous that the patient only gets 12 physical therapy sessions and she has tremendous atrophy. She will never improve to the point where she can go back to work until her strength improves. She will exercise at home but will do much better under the guidance of therapy.

4-1-11 MD., performed a Prospective Peer Review. The issue in dispute is the denial of preauthorization approval for twelve sessions of left knee physical therapy at as requested by Dr.. In response to the request for preauthorization, on 03/17/11, the Physician Advisor stated: "Deny: Injured Worker is status post arthroscopy of the knee on 01/13/11 with partial medial and lateral meniscectomies without chondroplasty. Injured worker has completed 12 sessions of physical therapy post operative. The last clinical note from the orthopedic surgeon is dated 02/21/11 at which time the injured worker was told to continue her physical therapy and follow up in three weeks. There are no current physical exam findings from the orthopedic surgeon or recent evaluation that would justify the medical necessity for continued physical therapy that exceeds the Official Disability Guidelines. Injured worker has completed Official Disability Guidelines recommended physical therapy following arthroscopy of the knee. The physician advisor completed peer to peer phone conversation with Dr. on 03/17/11 and attempted peer to peer phone conversation with Dr. on 03/17/11. They discussed case/clinical records and denial rationale. Call back information and due date were provided." In response to a request for reconsideration for twelve sessions of left knee physical therapy at as requested by Dr., on 03/30/11, the Physician Advisor stated: Deny: The request for reconsideration contained no objective information substantiating need for additional formal physical therapy. The request referred to previous surgeries to the same knee and subjective complaints that would necessitate exceeding Official Disability Guidelines criteria. However, progress note from Dr. of 02/21/11 documented excellent range of motion (120-0). It is not evident why, at this point, a home exercise plan would not be indicated. The physician advisor completed peer to peer phone conversation with Dr. on 03/29/11. They discussed case/clinical records and denial rationale." maintains its position that the proposed treatment for twelve sessions of left knee physical therapy at as requested by Dr. is not medically reasonable and necessary for the treatment of the compensable injury. Review of medical notes indicates that the claimant, who is a xx year old female, sustained a WC injury while working as a

on xx/xx/xx. The bus was struck by another vehicle causing injuries to both legs, arms, back knees and chest. There are multiple disputes including Grade IV chondromalacia of the left knee, cortical break and juxtacortical cyst, hypertension and depression, thoracic sprain/strain, carpal tunnel syndrome, right ankle and bilateral adhesive capsulitis of shoulders. The claimant is 5'9" and weighs approximately 273 pounds. Significant past medical history is positive for hypertension, uncontrollable bladder, acid reflux, obesity and a prior MVA in January 2005 where she suffered injuries to her back and both shoulders. The claimant has been employed through for around three months before the injury occurred. At the time of the accident, she was taken to the ER where she was diagnosed with cervical and lumbar strains and contusions with a tear in the lateral meniscus of her left knee. Treatment rendered has been extensive and included diagnostic studies, physical therapy, chiropractic care, use of TENS unit, steroid injections to her neck and lower back, a left knee arthroscopy with partial meniscectomy in August 2005, 20 sessions of chronic pain management program and an inpatient ACDF at C4-5 and C5-6 levels in September 2007. On 05/29/07, the claimant during a DWC-32 Designated Doctor Examination by, MD was certified at statutory MMI as of 02/14/07 and issued a 6% WP impairment rating for the permanent damage to the lumbar and left knee. The claimant has not returned to work since the injury. Additional treatment included the recently performed partial medial and lateral meniscectomies to the left knee done by Dr. on

01/13/11. According to the Lower Extremities Treatment Guidelines, the duration of treatment at any one level of care may be less than or greater than the recommended duration depending upon the documented condition of the injured worker. Last medical note from Dr. dated 02/21/11 reported the claimant with significant improvement after the surgery. Physical examination revealed excellent range of motion (120-0), her gait much improved, no instability, good pulses and a negative Hoffman's sign, and McMurray's and reverse McMurray's test also negative. As stated by the Physician Advisor, there are no other current physical exam findings from Dr. or recent evaluations that would justify the medical necessity for continued physical therapy that exceeds the Official Disability Guidelines. It is not evident why at this point a home exercise plan would not be indicated. Review of medical evaluation from DC dated 03/10/11 as noted by the Physician Advisor mostly referred to previous surgeries and treatments. Therefore, as indicated also by the Physician Advisor, the claimant should be independent with a home exercise program at this point of recovery. Further supervised twelve sessions of left knee physical therapy as suggested by Dr. is not substantiated by the ODG over the continuation with a home exercise program.

4-6-11 and 4-7-11 Hand written letters provided by the claimant.

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

REVIEW OF FILE SHOWS CLAIMANT HAS RECEIVED 12 SESSIONS OF POST-OPERATIVE PHYSICAL THERAPY FOLLOWING ARTHROSCOPIC MENISCAL SURGERY. GUIDELINES RECOMMEND A MAXIMUM OF 12 SESSIONS FOR THIS CONDITION WITH THE EXPECTATION THAT A PATIENT WOULD BE TAPERED TOWARD INDEPENDENCE IN A HOME PROGRAM AS THESE RECOMMENDED

SESSIONS APPROACH THEIR MAXIMUM. ALTHOUGH IT IS NOT CLEAR WHY THIS CLAIMANT COULD NOT HAVE EXTENDED PROGRESS WITH A HOME EXERCISE PROGRAM, SHE PRESENTS TO THE SURGEON RECENTLY WITH "OBVIOUS ATROPHY," A CLEAR INDICATION THAT EITHER THE HOME EXERCISE PROGRAM WAS NOT APPLIED OR IT WAS INSUFFICIENT TO ADDRESS THE REMAINING DEFICITS. THE 12 REQUESTED SESSIONS UNDER REVIEW WOULD BE EXCESSIVE AS THE CLAIMANT'S KNEE HAS OTHERWISE PROGRESSED WELL. THE NEED FOR 6 ADDITIONAL SESSIONS OF ACTIVE PHYSICAL THERAPY TO ADDRESS ATROPHY AND TO TRAIN, MODIFY AND MONITOR THE CLAIMANT'S HOME EXERCISE PROGRAM IS ESTABLISHED AS MEDICALLY REASONABLE AND NECESSARY.

ODG-TWC, last update 4-11-11 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 (e.g., 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 randomized 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 re injury, 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

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)