



Notice of Independent Review Decision-WC

DATE OF REVIEW: 4-27-11

CLAIMS EVAL

IRO CASE #:

*Utilization Review and
Peer Review Services*

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient physical therapy (PT) for 8 sessions (2 x 4) to the left knee area consisting of (1-4 units) therapeutic exercises, (1-4 units) neuromuscular re-education, (1-4 units) manual therapy, (1-4 units) therapeutic activities, (1-4 units) electrical stimulation, (1-4 units) ultrasound, (1-4 units) iontophoresis not to exceed four (4) units per session.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

Per The Employee's Report of Injury, the claimant sustained a work injury on xx/xx/xx. On this date, the claimant reported that she was walking in the marsh and she fell on some marsh roots. Her left knee hit hard.

12-1-10 PA- The claimant reported that she injured her knee while working at a marsh. She was stepping out of a thick marsh/mud and twisted her knee. She treated with OTC medications. On exam, the claimant has pain to palpation at the medial, lateral and anterior joint line and over the lateral and inferior patella. Sensation is intact. 2/4 patellar tendon reflex. Range of motion is full. The claimant has positive anterior drawer sign and Lachman. Assessment: ACL strain left knee and knee pain. Plan: MRI of the left knee. The claimant is to continue with OTC and referral to ortho.

12-6-10 MRI of the left knee showed status post ACL reconstruction with intact appearing ACL graft. Changes related to prior partial medial meniscectomy. There is not evidence of recurrent medial meniscal tear. Minimal joint effusion.

Physical therapy notes on 12-8-10, 12-20-10, 12-22-10, 12-27-10, 12-29-10, 1-3-11, 1-6-11, 1-11-11, 1-14-11, 1-18-11.

12-15-10 Follow up with PA., notes the claimant continues to have pain in both knees. The claimant was placed on Celebrex and referred to ortho for evaluation. The claimant is to continue with home exercise program and full duty.

1-6-11 MD., notes the claimant is a female seen at the request of P.A.-C., for evaluation of her left knee. Her left knee has been bothering her since xx/xx/xx. At that time she was walking when her left leg got stuck in a bar. She then twisted to the left and thinks she twisted her left knee somewhat. She didn't have a whole lot of pain then but it has continued to bother her since that time. Her pain is directly on the anterior aspect of the knee. She has a long history of problems with this left knee. Back in 1996 she underwent an ACL reconstruction as well as meniscal repair. She has done great from this until last year. Last year she injured her knee and had what sounds like a partial medial meniscectomy with an arthroscopy. She actually did okay from this until xx-xx-xx. She said now her pain is about a 3/10 with 10 being the worst. She did try physical therapy and this did not help her. She takes Celebrex, which does seem to help. She has not had any cortisone injections. She has not worn a brace. Her left knee is worse with increased activity and better when she rests it. A new MRI was obtained and she came over here for further evaluation. On exam, her knee shows well healed incisions from her ACL reconstruction. There is full range of motion. She has trace patellofemoral crepitus. There is minimal pain with patellofemoral compression. She has mild medial joint line tenderness and is nontender about the lateral joint line. She has negative Lachman. The knee shows general external configuration and alignment are normal. The patient has a normal gait. There are no skin lesions or masses. There is no effusion. There is no gross extensor malalignment. The patient has a negative McMurray and a negative anterior and posterior drawer. There is no posterolateral instability. There is no opening to varus and valgus stress at 0 or 30 degrees. The patient is able to move her toes and ankle up and down very well. There is normal sensation distally with 2+ DP and PT pulses. Left hip demonstrates FROM without pain. Plan: The patient's diagnosis and treatment options are discussed with the patient in terms she can understand. He had a long discussion regarding treatment options. He fitted her with a patellar stabilizer brace today. Hopefully this will help her. He also

talked about injecting her knee to calm it down a little bit and she agrees. He told her to give me a call if she has further problems with her knee.

Follow up with PA., on 1-14-11 notes the claimant is still having pain. There has not been any improvement. On exam, she has bursal swelling, crepitus and slight lateral tilt, special testing was not performed. Plan: The evaluator felt that the claimant needed to take it easy when the knee acts up. He told the claimant to expect episodes of swelling with increased activity. The claimant was placed on full duty.

2-14-11 MD., the evaluator recommended physical therapy and follow up prn. He felt the claimant had sprain of cruciate ligament of the knee. The claimant was returned to work without restrictions.

Physical therapy on 2-25-11, 3-11-11, 3-18-11, and 3-25-11.

3-1-11, MD., performed a Utilization Review. He noted that this claimant was injured while walking in a marsh and tripped on some roots. Diagnosis is left knee strain 844.2. Request is for PT eight sessions. Claimant has already had 12 sessions. Last office visit shows claimant with chondromalacia of patella and weakness of hip musculature. There is a positive Ober's test. Claimant tends to walk on outside of feet.

Range of motion was 144 degrees flexion, 0 degrees extension. Drawer exams were negative, The ODG supports up to 12 sessions for this diagnosis. Injured worker should be on home exercise program at this point. The patient has reached maximal amount of treatment suggested for this condition. There is nothing in the information furnished that indicates a need to deviate from the guidelines. This is not to say that additional therapy is not needed, but only that it need not be administered through a skilled therapists but rather through the active independent home exercise program advocated by the ODG and the American College of Occupational medicine evidence-based guidelines. Also further assessment may be necessary and reasonable to determine why the patient is not responding. If the patient needs more than the recommended number of sessions, diagnostics are recommended to identify undiagnosed pain generators. Therefore the request is not approved.

3-17-11 DO., performed a Utilization Review. This female was injured. The claimant was injured while walking in a marsh and tripped over some roots. The initial diagnosis was left knee strain. The claimant has completed twelve sessions of physical therapy. On 2-14-11, the claimant indicated knee pain anterior medial on a daily basis. Running aggravated the pain. Physical exam revealed medial joint line and patellar tenderness with no instability and pain with patellar compression. Radiographically, no fracture or dislocations were noted, joint spaces did not have narrowing. The claimant was recommended to have physical therapy for patellar femoral program. On 2-25-11 the claimant was evaluated with physical therapy noting the claimant having 0-144 motion and 5/5 strength. The claimant was assessed to have symptoms with chondromalacia patellar and hip musculature weakness leading to faulty biomechanics. There was a positive Ober's test for tightness on the left. The prior physical therapy notes are not provided for review. Dr. notes dated 2-14-11 did not discuss previous treatment to be

able to determine if the claimant had appropriate rehab for the patellar femoral and hip findings noted on the Physical therapy evaluation of 2-25-11. At this time, without better documentation of previous treatment of claimant's response the current request for eight additional sessions of physical therapy cannot be authorized.

3-30-11, MD., the claimant has been treated for an ACL sprain. She has had physical therapy without improvement. The evaluator felt that it would be to her benefit to try extensive therapy at a new facility that is best suited for her type of injury.

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

A VALID RATIONALE HAS NOT BEEN SUBMITTED IDENTIFYING AS TO WHY ANY REMAINING REHAB COULD NOT BE PERFORMED WITHIN THE CONTEXT OF A PRESCRIBED AND SELF-ADMINISTERED PROGRAM. APPLICABLE ODG CRITERIA SUPPORTS A PRESCRIBED AND SELF-ADMINISTERED PROGRAM, BASED ON THE OBJECTIVE FINDINGS AND APPLICABLE CRITERIA OVERALL. THEREFORE, OUTPATIENT PHYSICAL THERAPY (PT) FOR 8 SESSIONS (2 X 4) TO THE LEFT KNEE AREA CONSISTING OF (1-4 UNITS) THERAPEUTIC EXERCISES, (1-4 UNITS) NEUROMUSCULAR RE-EDUCATION, (1-4 UNITS) MANUAL THERAPY, (1-4 UNITS) THERAPEUTIC ACTIVITIES, (1-4 UNITS) ELECTRICAL STIMULATION, (1-4 UNITS) ULTRASOUND, (1-4 UNITS) IONTOPHORESIS NOT TO EXCEED FOUR (4) UNITS PER SESSION IS NOT REASONABLE OR 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 (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

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)