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Notice of Independent Review Decision

DATE OF REVIEW: 06/4/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions physical therapy for the right knee at Karen Wood Physical Therapy as requested by Dr. Steven Nolan

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

Board Certified Orthopedic Surgeon.

REVIEW OUTCOME:

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

Upheld (Agree)

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:

Cover sheet and working documents

Utilization review determination dated 04/20/12, 05/04/12

Prospective review response dated 05/15/12

Office visit note dated 02/06/12, 02/13/12, 03/08/12, 03/22/12, 04/11/12, 04/12/12, 04/26/12, 05/17/12

Case management report dated 03/16/12-03/31/12, 04/01/12-04/15/12, 04/16/12-04/30/12

Flow sheets

Appeal letter undated

Handwritten note dated 03/19/12

MRI right knee dated 02/09/12

Addendum dated 02/17/12

Operative report dated 03/09/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient twisted his right knee while coming down the stairs at work. MRI of the right knee dated 02/09/12 revealed meniscal tear extends to the inner free edge of the posterior horn of the medial meniscus extending to its root; there is a partial tear involving approximately half the fibers of the distal half of the ACL; tricompartmental osteoarthritic changes; grade I strain of the MCL, moderate

sized joint effusion and Baker's cyst. The patient underwent right knee arthroscopy with partial medial meniscectomy, debridement of the damaged articular cartilage of the medial femoral condyle and patellofemoral joint and major synovectomy of the medial compartment and lateral compartment on 03/09/12. Follow up note dated 04/26/12 indicates that the right knee effusion is down. He still has significant quadriceps atrophy. Range of motion is quite good at 0 degrees of extension to almost 140 degrees of flexion. There is minimal joint line tenderness. McMurray's and reverse McMurray's are negative. There is no ligamentous instability and no calf tenderness. There is a negative Homan's sign and a good distal pulse in the right lower extremity. The patient has completed 12 postoperative physical therapy visits to date.

Initial request for 12 sessions of physical therapy was non-certified on 04/20/12 noting that the submitted clinical notes do not include any detailed clinical notes from the requestor that would outline current subjective complaints or objective clinical findings that would justify the medical necessity for ongoing supervised PT. The denial was upheld on appeal dated 05/04/12 noting that there are no physician notes to justify extending PT beyond the current 12 visits following a knee injury. It is unclear if there has been surgery or what the specific diagnosis is. The request for 12 visits appears to exceed ODG standards and demonstrates no attempt to taper to a home based program.

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

Based on the clinical information provided, the request for 12 sessions of physical therapy for the right knee is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent right knee arthroscopy with partial medial meniscectomy, debridement of the damaged articular cartilage of the medial femoral condyle and patellofemoral joint and major synovectomy of the medial compartment and lateral compartment on 03/09/12 and has completed 12 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 12 visits of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Knee and Leg Chapter

Physical medicine	Recommended. Positive limited evidence. As with any treatment, if there is no improvement after 2-3 weeks the
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treatment	<p>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</p>
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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 specific physical therapy modalities by name, as well as [Exercise](#). See also [Activity restrictions](#); [ACL injury rehabilitation](#); [Aquatic therapy](#); [Barefoot walking](#); [Cold/heat packs](#); [Compression garments](#); [Computerized muscle testing](#); [Continuous-flow cryotherapy](#); [Continuous passive motion \(CPM\)](#); [Deep transverse friction massage \(DTFM\)](#); [Diathermy](#); [Durable medical equipment \(DME\)](#); [Electromyographic biofeedback treatment](#); [Electrothermal shrinkage](#) (for lax ACL); [Flexionators](#) (extensionators); [Footwear, knee arthritis](#); [Functional improvement measures](#); [Functional restoration programs \(FRPs\)](#); [Gait training](#); [Game Ready™](#) accelerated recovery system; [Gym memberships](#); [Home exercise kits](#); [Immobilization](#); [Interferential current](#)

[stimulation \(ICS\)](#); [Iontophoresis](#); [Joint active systems \(JAS\) splints](#); [Kinesio tape \(KT\)](#); [Knee brace](#); [Low level laser therapy \(LLLT\)](#); [Magnet therapy](#); [Manipulation](#); [Manual therapy](#); [Massage therapy](#); [Mechanical stretching devices](#) (for contracture & joint stiffness); [Non-surgical intervention for PFPS](#) (patellofemoral pain syndrome); [Phonophoresis](#); [Power mobility devices \(PMDs\)](#); [Static progressive stretch \(SPS\) therapy](#); [Stretching and flexibility](#); [Tai Chi](#); [Taping](#); [Therapeutic knee splint](#) (patellofemoral pain); [Traction, knee](#) (skeletal traction treatment); [Ultrasound, therapeutic](#); [Walking aids](#) (canes, crutches, braces, orthoses, & walkers); [Work conditioning, work hardening](#).

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

	<p>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 Post-surgical treatment (ORIF): 30 visits over 12 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 Work conditioning See Work conditioning, work hardening</p>
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