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Notice of Independent Review Decision

DATE OF REVIEW: March 17, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Aquatic Therapy 3xWk x 3Wks 97110 97150 97035

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

This physician is Board Certified in Occupational Medicine with over 34 years of experience.

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:

03/18/11: Evaluation by with
03/21/11: Initial Physical Therapy Evaluation by with
03/31/11: Physical Therapy Note by
04/01/11: PT Daily Progress Note
04/04/11: PT Daily Progress Note by
04/08/11: PT Daily Progress Note by
04/11/11: Evaluation by
04/13/11: PT Daily Progress Note by
04/15/11: PT Daily Progress Note by
04/20/11: PT Daily Progress Note by
04/22/11: Physical Therapy Re-evaluation by
04/25/11: PT Daily Progress Note by
05/02/11: Evaluation by
05/23/11: Evaluation by
07/01/11: MRI Left Knee without Contrast interpreted by
07/14/11: Evaluation by

08/31/11: Operative Report by
09/06/11: Evaluation by
09/21/11: Evaluation by
09/26/11: Evaluation by
10/10/11: Evaluation by
10/25/11: Evaluation by
11/09/11: MRI Left Knee with and without IV Contrast interpreted by
11/10/11: Initial Physical Therapy Evaluation
11/16/11: Evaluation by
11/18/11: PT Daily Progress Note
11/21/11: PT Daily Progress Note
11/23/11: PT Daily Progress Note
11/28/11: PT Daily Progress Note
11/30/11: PT Daily Progress Note
12/02/11: PT Daily Progress Note
12/05/11: PT Daily Progress Note
12/06/11: PT Daily Progress Note
12/07/11: PT Daily Progress Note
12/16/11: Evaluation by
12/27/11: Physical Therapy Re-evaluation by
12/28/11: PT Daily Progress Note by
12/29/11: PT Daily Progress Note by
01/10/12: PT Daily Progress Note by
01/11/12: PT Daily Progress Note by
01/12/12: PT Daily Progress Note by
01/13/12: Evaluation by
01/16/12: PT Daily Progress Note by
01/19/12: PT Daily Progress Note by
01/20/12: PT Daily Progress Note by
01/23/12: Functional Capacity Evaluation performed by
01/24/12: PT Daily Progress Note by
01/25/12: Chart Note by
01/27/12: Report of Medical Evaluation by
01/31/12: UR performed by
02/08/12: UR performed by
02/10/12: Evaluation by

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx when she was stepping down from her chair at work and twisted her left knee. Her past surgical history is positive for 6 spinal surgeries, right hip replacement, left knee surgery in 1977 and right knee surgery in 1978 for dislocating patella. She had been doing well until the new injury. She was initially seen at the where x-rays were performed and she was given crutches.

03/18/11: The claimant was evaluated by for left knee pain, swelling, catching, and locking to the left knee since the injury on 03/08/11. On physical examination

there was mild soft tissue swelling noted. She did walk with a limp. Range of motion was 0 degrees to 130 degrees. There was tenderness along the medial joint line, mild tenderness along the posterolateral aspect of the knee. No varus or valgus instability. Patellar apprehension was negative. No pain with ROM of her left hip. Diagnosis: Internal derangement/sprain left knee with previous history of patella realignment surgery. Recommendation: Knee brace, crutches, and physical therapy. She was prescribed Lortab 5 mg and place on Light duty work.

03/21/11: The claimant had an Initial Physical Therapy Evaluation by for pain at the back and outside of the left knee with 7/10 vas pain score. The claimant also reported feeling pain at the bottom of the heel and numbness to her ankle/foot. On physical examination ROM of the left knee was -5 to 115. Knee strength: left quad 4-/5, hamstring 3+/5 with pain. There was tenderness to palpation of the knee most at the popliteal region, some at lateral joint line and medial aspect of the left knee. Genu Valgus was noted. She had an antalgic gait and was FWB. She presented wearing a left knee brace and using 2 crutches. She was able to (U) stance (L) LE < 5 seconds without LOB. Problem List: Includes decreased ROM, decrease ADL function, decreased balance/proprioception, decreased strength, decreased work ability, impaired gait, joint pain, painful ROM, tenderness with palpation. Plan: PT 2-3 x/week x 5 week prn. Treatment would consist of group therapy (97150), modalities, progressive exercises, Therapeutic activities (97530), gait training (97116), Aquatic therapy (97113).

04/11/11: The claimant was re-evaluated by who noted she reported "My left knee is feeling a little bit better". It was noted the claimant was just using a cane now. On physical exam there was no significant swelling, range of motion was 0 degrees to 130 degrees, and there was mild tenderness along the medial parapatellar region. recommended completing her physical therapy.

04/22/11: The claimant had a Physical Therapy Re-evaluation by who noted the claimant felt she was 80% back to normal. Problem List: LOM and strength with LLE flexion, gait deviations, pain with palpation, decreased ability for prolonged standing and walking and loss of ability to squat or kneel during home activities. The claimant has met STGs and partially met LTGs. Plan: Continue with modalities PRN. Continue therapy as to tolerance to exercise, continue home exercises as instructed.

05/02/11: The claimant was re-evaluated by who indicated she had completed therapy and was definitely doing better, however that something was moving within her knee and she would have occasional locking. On exam there was minimal tenderness, good ROM, and no instability. Diagnosis: Left knee sprain with history of previous patellar realignment surgery. Recommendation: At this time things appeared stable, if locking persisted, would consider MRI.

05/23/11: The claimant was re-evaluated by who indicated she continued to have some locking within the knee, however did not feel as though her kneecap came

out of place. On exam there was tenderness to the lateral joint line and medial joint line. Mild pain with flexion of the knee. Negative patellar apprehension sign. Diagnosis: Internal derangement, left knee and left knee sprain with history of previous patellar realignment surgery. Recommendation: MRI of the left knee.

07/01/11: MRI Left Knee without Contrast interpreted by Impression: 1. Chronic anterior cruciate ligament tear with evidence for prior MCL sprain and degeneration of the posterior cruciate ligament. 2. Complex lateral meniscus tear with lateral meniscus extrusion and grade-4 chondrosis in the lateral compartment as well as lateral compartment osteoarthritis. 3. Early degenerative osteoarthritis at the patellofemoral and medial compartment with a focal 5 mm full-thickness cartilage defect on the lateral patellar facet. 4. Extensor mechanism tendinosis at the quadriceps insertion and throughout the patellar tendon. 5. Left knee effusion.

07/14/11: The claimant was re-evaluated by On physical exam there was mild swelling, tenderness to the lateral joint line, pain with McMurray's maneuver laterally. No appreciable Lachman's laxity or appreciable pivot shift. Diagnosis: Tear lateral meniscus knee, left knee with what appears to be a chronic ACL tear and arthritis. Recommendations: Left knee arthroscopy.

08/31/11: Operative Report by. Postoperative diagnosis: Lateral femoral condylar chondromalacia, patellar chondromalacia, chondromalacia of the trochlear groove of the knee, lateral tibial plateau chondromalacia. Procedure: Left knee arthroscopic partial lateral meniscectomy.

09/06/11: The claimant was re-evaluated by who noted that it was discussed that is was highly likely she would require a knee replacement in the future. Her sutures were removed at this visit.

09/21/11: The claimant was re-evaluated by who noted she felt like her kneecap went out of place. On exam there was mild swelling of her left knee. No erythema or warmth. There was discomfort with ROM. She had a positive patellar apprehension sign. Diagnosis: Lateral meniscal tear, left knee with preexisting significant arthrosis with prior history of patellar problems. Recommendations: A patella J brace.

10/10/11: The claimant was re-evaluated by who noted she was still having pain and giving way to her left knee. On exam she had tenderness along the lateral femoral condyle, and lateral joint line pain with flexion of the left knee. Weight bearing exercise of the left knee demonstrated moderate narrowing of the lateral compartment with valgus deformity. Recommendations: A brace to help unload the lateral compartment and they would await approval for the Synvisc injection.

10/25/11: The claimant was re-evaluated by who indicated that x-rays at the last visit showed moderate arthrosis with valgus deformity of the left knee. Recommendations: MRI arthrogram of the left knee.

11/09/11: MRI Left Knee with and without IV Contrast interpreted by. Impression: 1. Progressive tricompartmental osteoarthritis since a study from 07/01/2011. There is now a radial tear at the posterior root of the medial meniscus with medial meniscus extrusion. The lateral meniscus is now extruded and there is now full-thickness cartilage loss in the lateral compartment. There is a moderate-sized left knee effusion. 2. Chronic anterior cruciate ligament tear. 3. Chronic patellar tendinosis.

11/10/11: The claimant had an Initial Physical Therapy Evaluation by. Problem List: decreased joint mobility, decreased ADL function, decreased strength, decreased weight bearing tolerances, decreased work ability, edema, impaired gait, joint pain, impaired sleep, painful ROM, tenderness with palpation. Plan: Therapy 2-3 x/week. Treatment would consist of Aquatic therapy (97113), gait training (97116), Iontophoresis (97035), Cold Pack (97010), ESTM (97014), Hot Pack (97010), IF (97014), Neuromuscular re-ed (97112), Phonophoresis (97139), ultrasound (97035).

11/16/11: The claimant was re-evaluated by who indicated they were still awaiting approval for the Synvisc injection and knee brace to help with the lateral compartment.

12/27/11: The claimant had a Physical Therapy Re-evaluation by Angela Bosh, MPT who reported that the claimant was trying not to walk with crutches at home, but that she has "to use the counters or the walls to balance myself". The claimant felt unstable and walks "side to side; wobbly" when she is walking. The claimant has a lot of muscle weakness and poor balance with her left knee. She was trying to weight bear onto her leg more, but felt her leg was going to give way. Assessment: PT demonstrated improvements with overall function, however, she continued to have ligamentous instability with open chain positions and movements. PT would benefit from continued skilled therapy for therapeutic exercises, gait training, modalities PRM, NMS for ms re-education, balance/proprioception activities. PT may also benefit from use of a knee brace for all gait activities and ADLs/IADLs for safety. Problem List: decreased balance/proprioception, decreased strength, decreased weight bearing tolerances, decreased work ability, impaired gait, tenderness with palpation. It was documented that she showed independence on the use of Home Exercise Program.

01/13/12: The claimant was re-evaluated by who noted the request for the Synvisc injection was not received, therefore they would resubmit. The claimant reported her left knee still hurt and therapy has helped. On exam there was tenderness to the medial femoral condyle, medial joint line and lateral femoral condyle. She did have pain with flexion of the knee. No significant swelling was noted. Recommendations: Synvisc injection and a FCE. A Velcro strap knee brace was ordered since the custom brace was not approved.

01/23/12: The claimant underwent a Functional Capacity Evaluation performed by. Based on the results she demonstrated an inability to return to full duty as a bank teller. She was still very symptomatic with reports of pain to her left knee, as well as to her back. She does have multiple comorbidities including having three lumbar surgeries with a fusion to L3. She also had a right hip replacement. It was noted that it is imperative that she continue with her therapy to try to get some more core stability and strengthening of the knee and her back. She did demonstrate good effort and sincere motivation and determination throughout the FCE. It was reported that she would eventually benefit from a work conditioning program, but because of her comorbidities, she had a need for continued physical therapy as well as aquatic therapy.

01/24/12: PT Daily Progress Note by. Assessment: PT is making steady progress towards achieving rehabilitation goals. PT continues to require the use of her bilateral crutches and demonstrates balance deficits, gait deviations, LE weakness and loss of proprioception. PT would benefit from continued therapy for progression of I HEP for strengthening, flexibility, balance/proprioception and pain control methods.

01/25/12: Chart Note by who agreed for continued therapy and aquatics.

01/27/12: The claimant was evaluated by a designated doctor. opined the claimant had obtained maximal medical improvement as of January 2, 2012 with a 1% whole person impairment.

01/31/12: UR performed by. Rationale for Denial: This is a request for nine Aquatic Therapy visits to the left knee. The clinical information submitted does not indicate any evidence that the patient is not capable of tolerating land-based aerobic exercises to justify the request for aquatic therapy. The specific short and long term therapy goals of the proposed service were also unspecified. The patient has previously undergone Physical Therapy, and as per 1/24/12 report, it was noted that the patient has been making progress towards rehabilitation goals. The patient was also noted to be participating in home exercises. Compliance must likewise be included for review. In addition, the requested number of visits exceeds the recommendations. When treatment duration or number of visits exceeds the guideline, exceptional factors should be noted. As such, the medical necessity of the proposed service has not been substantiated.

02/08/12: UR performed by. Rationale for Denial: Upon review of the report, there is still no clinical information submitted to indicate evidence that the patient is not capable of tolerating land-based aerobic exercises to justify the request for aquatic therapy. Also, the specific short and long term therapy goals of the proposed service were still not specified. If indeed the patient is not yet fully improved, factors of prolonged or delayed recovery should be identified and addressed rather than pursuing a continued therapy that provides no complete benefit. Furthermore, the number of requested visits on top of the previous therapy sessions exceeds the recommendation of the referenced guidelines. As

the guidelines indicate, when treatment duration exceeds the recommendation, exceptional factors should be noted. There are none in the records submitted that mention such exceptional factors. With these, the previous non-certification of the request is upheld.

02/10/12: The claimant was re-evaluated by who indicated that the claimant was just a little bit better to her left knee. On exam there was mild swelling. There was less sensitivity and tenderness on palpation as compared to before. She did walk with a limp and was using crutches. Recommendations: A strengthening program for eight sessions for the knee.

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

The claimant is a female who was injured on xx/xx/xx when she was stepping down from her tall chair at work and twisted her left knee. She received 5 therapy treatments before an MRI revealed a torn meniscus of the left knee and claimant had surgery for a torn meniscus on 8/31/11. She then received 20 postsurgical therapy treatments. Her recovery has been slow although some of the notes reflect intermittent improvement to 80% return of function. On January 2, 2012 she was deemed at MMI and given 1% IR. This is a request for more aquatic therapy treatments.

ODG/knee states aquatic therapy is "Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, especially deep water therapy with a floating belt as opposed to shallow water requiring weight bearing, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Aquatic exercise appears to have some beneficial short-term effects for patients with hip and/or knee osteoarthritis while no long-term effects have been documented. Positive short-term effects include significantly less pain and improved physical function, strength, and quality of life."([Bartels-Cochrane, 2007](#)) ([Hinman, 2007](#)).

ODG/Knee/ Postsurgical therapy recommends up to 18 postsurgical therapy treatments for the diagnosis of a torn meniscus which this claimant has had. A significant portion of these treatments have been aquatic therapy treatments. ODG endorses aquatic therapy early in the course of treatment but not indefinitely. Late in the course of this claimants recovery she developed tri-compartmental osteoarthritis which is an unexpected complication that does not seem to be responding to additional therapy. Therefore, medical necessity has not been established. Delayed recovery necessitates investigation for another type of remedy rather than pursuit of treatments that do not seem to be helping. For these reasons I am not endorsing this request for additional aquatic therapy as it is not supported by the ODG nor is it supported by the claimant's clinical course. The previous adverse decisions have been upheld.

ODG:

Aquatic therapy

Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, especially deep water therapy with a floating belt as opposed to shallow water requiring weight bearing, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Aquatic exercise appears to have some beneficial short-term effects for patients with hip and/or knee osteoarthritis while no long-term effects have been documented. Positive short-term effects include significantly less pain and improved physical function, strength, and quality of life. ([Bartels-Cochrane, 2007](#)) ([Hinman, 2007](#)) Results suggest that aquatic exercise does not worsen the joint condition or result in injury. ([Wang, 2007](#)) ([Wyatt, 2001](#)) According to one study, aquatic exercises can also be usefully and safely implemented in the rehabilitation program following ACL surgery, and whenever it is important to avoid excessive shear joint forces that constrain the tibial plateau anterior translation with respect to the femur. ([Biscarini, 2007](#)). This study showed that novel underwater treadmill exercise training performed by overweight and obese men and women is an effective training modality, producing beneficial changes in body composition and improvements in physical fitness, and can minimize pain and injury, especially in obese populations and in others suffering from orthopedic injury. Underwater treadmill and land treadmill training were equally capable of improving aerobic fitness and body composition in physically inactive overweight individuals, but underwater treadmill training may induce increases in leg lean body mass. ([Greene, 2009](#)) In patients with hip or knee arthritis, both aquatic and land based exercise programs appear to result in comparable outcomes for function, mobility or pooled indices. For people who have significant mobility or function limitations and are unable to exercise on land, aquatic exercise is a legitimate alternative that may enable people to successfully participate in exercise. ([Batterham, 2011](#)) Initiating aquatic therapy just 6 days after total knee arthroplasty (TKA) improved patient-reported outcomes compared with starting therapy 14 days after surgery, according to this RCT. Aquatic therapy is useful for TKA rehabilitation because it allows patients to exercise in an environment that relieves body weight while muscular strength is gradually restored. Patients do not usually start aquatic therapy until 14 days after surgery, to allow the wound to heal. This RCT showed that the use of early aquatic therapy has opposite effects in terms of health-related quality of life after THA when compared with TKA. The authors speculated that one important explanation for the greater improvement with early aquatic therapy for TKA patients is a lower level of satisfaction that TKA patients typically have after the procedure compared with hip patients. ([Liebs, 2012](#)) For recommendations on the number of supervised visits, see [Physical therapy](#).

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 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 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](#)

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)**