

ReviewTex. Inc.

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Notice of Independent Review Decision

Date notice sent to all parties:

November 15, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal physical therapy 3xwkX4wks to left lower extremity (hip, thigh, knee, leg)

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

Board Certified Neurology

REVIEW OUTCOME:

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

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Cover sheet and working documents
2. MRI lumbar spine dated 12/07/11
3. Electromyography report dated 04/21/12
4. Appeal letter for physical therapy dated 07/16/12
5. Physical examinations at Balance dated 08/03/12 and 08/31/12
6. Utilization review determination dated 08/08/12
7. Office visit notes Dr. dated 08/23/12
8. Utilization review determination dated 09/11/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was walking back to her desk from the restroom when her shoe stuck to the floor, her foot stopped and the rest of her body kept going, but she did not completely fall. She injured her low back, left hip and left knee. MRI of the lumbar spine dated 12/07/11 revealed intervertebral disc degeneration with mild to moderate bulging from L3-4 to L5-S1; facet arthropathy is seen most marked at L4-5. Superimposed mild broad right foraminal protrusion at L2-3 and mild broad posterior central protrusion at L5-S1 is noted. There is mild to moderate compression of the thecal sac at L3-4 and L4-5 and to a lesser degree at L5-S1. EMG/NCV dated 04/21/12 revealed no radicular/discogenic component on her exam. Note dated 08/23/12 indicates that the patient has completed 5 weeks of physical therapy. The patient is noted to work full time without restrictions. Physical examination on 08/31/12 indicates that left hip flexion is 100, extension 20, abduction 30, adduction 20, IR 20 and ER 30 degrees. Left knee range of motion is extension 10, flexion 110, varus angle 20, valgus angle 20, IR and ER 5 degrees. Lumbar range of motion is flexion 45, extension 20, bilateral lateral flexion 20 degrees. Straight leg raising is positive on the left, Kemp's test is positive on the left and Patrick's test is positive on the left. Diagnoses are lumbar sprain, sprain of unspecified site of hip and thigh and sprain of unspecified site of knee and leg. The initial request for physical therapy was non-certified on 08/08/12 noting that the patient continues to work full time. The diagnoses are cited as non-specific sprains of the hip and knee following the incident almost one year ago. The orthopedic consultation has not yet been obtained and pending the identification of specific and objective signs of physical impairment and functional limitation, the medical necessity for skilled physical therapy services for the left leg cannot be established at this time. The denial was upheld on appeal dated 09/11/12 noting that the patient's major clinical finding is slight restriction of lumbar motion. Information provided does not identify any deficits that would benefit from supervised treatment.

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 physical therapy 3 x wk x 4 wks to left lower extremity (hip, thigh, knee, leg) is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. It is unclear how many sessions of physical therapy the patient has completed to date, and the patient's objective, functional response to therapy is not provided to establish efficacy of treatment and support additional sessions. The patient's compliance with an active home exercise program is not documented. There are no specific, time-limited treatment goals provided. The patient is noted to have sustained nonspecific sprain/strain injuries which should have resolved at this time. Given the current

clinical data, the requested physical therapy is not indicated as medically necessary.

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

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Hip and Pelvis Chapter

Physical medicine treatment	<p>Recommended as indicated below. A physical therapy program that starts immediately following hip injury or surgery allows for greater improvement in muscle strength, walking speed and functional score. (Jan, 2004) (Jain, 2002) (Penrod, 2004) (Tsauo, 2005) (Brigham, 2003) (White, 2005) (National, 2003) A weight-bearing exercise program can improve balance and functional ability to a greater extent than a non-weight-bearing program. (Expert, 2004) (Binder, 2004) (Bolgla, 2005) (Handoll, 2004) (Kuisma, 2002) (Lauridsen, 2002) (Mangione, 2005) (Sherrington, 2004) Patients with hip fracture should be offered a coordinated a multidisciplinary rehabilitation program with the specific aim of regaining sufficient function to return to their pre-fracture living arrangements. (Cameron, 2005) 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) Behavioral graded activity (BGA) is an individually tailored exercise program in which the most difficult physical activities are gradually increased over time and the exercises are specifically designed to improve impairments limiting the performance of these activities. In the long-term, both BGA and usual PT care were associated with beneficial effects in patients with hip and knee OA. In patients with knee OA, there were no between-group differences at short-, mid-long, and long-term follow-up. In contrast, patients with hip OA had significant differences favoring BGA. (Pisters, 2010) For patients with hip replacement, earlier and more intensive rehabilitation was associated with better outcomes. (Dejong, 2009) The most successful hip fracture PT programs involve more intensive exercise, but PT is often prescribed in doses and modalities that are insufficient to generate physiological adaptation. The potential risks of more intensive physical therapy appear to be minimal. (Stott, 2011) A Cochrane review on in restoring mobility after hip fracture surgery provides limited guidance, with inconsistent results from various trials. Some trials found improved mobility from a two-week weight-bearing program, a quadriceps muscle strengthening program and electrical stimulation aimed at alleviating pain. There was no significant improvement in mobility from a treadmill gait retraining program, 12 weeks of resistance training, and 16 weeks of weight-bearing exercise. Of two trials evaluating more intensive physical therapy regimens, one found no difference in recovery, and the other reported a higher level of dropout in the more intensive group. Started soon after hospital discharge, two trials found improved outcome after 12 weeks of intensive physical training and a home-based physical therapy program. Begun after completion of standard physical therapy, one trial found improved outcome after six months of intensive physical training, one trial</p>
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	<p>found increased activity levels from a one year exercise program, and one trial found no significant effects of home-based resistance or aerobic training. Another trial found improved outcome after home-based exercises started around 22 weeks from injury, and a trial found home-based weight-bearing exercises starting at seven months produced no significant improvement in mobility. (Handoll, 2011)</p> <p>ODG Physical Medicine Guidelines – Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less). Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.</p> <p>Sprains and strains of hip and thigh (ICD9 843): 9 visits over 8 weeks</p> <p>Dislocation of hip (ICD9 835): 9 visits over 8 weeks</p> <p>Fracture of neck of femur (ICD9 820): Medical treatment: 18 visits over 8 weeks Post-surgical treatment: 24 visits over 10 weeks</p> <p>Fracture of pelvis (ICD9 808): Medical treatment: 18 visits over 8 weeks Post-surgical treatment: 24 visits over 10 weeks</p> <p>Osteoarthritis and allied disorders (ICD9 715): Medical treatment: 9 visits over 8 weeks Post-injection treatment: 1-2 visits over 1 week Post-surgical treatment: 18 visits over 12 weeks</p> <p>Arthropathy, unspecified (ICD9 716.9): Post-injection treatment: 1-2 visits over 1 week Post-surgical treatment, arthroplasty/fusion, hip: 24 visits over 10 weeks</p> <p>Work conditioning (See also Procedure Summary entry): 9 visits over 8 weeks</p> <p><i>In addition, active self-directed home PT may include Simple Hip-Strengthening Exercises:</i></p> <p>Hip-flexors — Standing beside a chair, without bending at the waist, bend one knee up as close to chest as possible. Lower leg to floor. Repeat with other leg.</p> <p>Hip abductors — Standing erect and holding onto the back of a chair, without bending at the waist or knee, move one leg straight out to the side, making sure that the toes point forward. Lower the leg and repeat on other side.</p> <p>Hip-extensors — Stand holding onto the back of a chair, and bend forward about 45 degrees at the hips. Lift one leg straight out behind you as high as possible without bending the knee or moving the upper body. Lower leg and repeat on other side.</p>
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ODG Knee and Leg Chapter

Physical medicine treatment	<p>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</p>
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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

Quadriceps tendon rupture (ICD9 727.65)
 Post-surgical treatment: 34 visits over 16 weeks

Patellar tendon rupture (ICD9 727.66)
 Post-surgical treatment: 34 visits over 16 weeks

Work conditioning
 See [Work conditioning, work hardening](#)