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Notice of Independent Review Decision

Date notice sent to all parties:

October 29, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97110, therapeutic exercises, 9 units

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:

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:

Cover sheet and working documents
Utilization review determination dated 09/27/12, 10/03/12
Procedure note dated 08/23/12, 08/29/12, 08/30/12, 09/05/12, 09/07/12, 09/10/12, 09/12/12, 09/13/12, 09/19/12, 09/21/12
History and physical dated 09/24/12
Office visit note dated 09/06/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male . On this date the patient sustained a left tibial plateau fracture. The patient underwent initial surgery to repair fracture at the time of injury and second surgery consisting of ORIF on 03/21/12. Most recently, the patient has undergone 10 sessions of physical therapy from 08/23/12 to 09/21/12. Office visit note dated 09/06/12 indicates that without his brace, the patient says his knee feels unstable. History and physical dated 09/24/12 indicates that the patient sustained a left tibial plateau fracture and has completed 53 physical therapy visits to date. On physical examination range of motion of the left knee is flexion 127, extension 0. Strength is rated as 4-/5 flexion, 3+/5 extension. Pain level is rated as 2/10.

Initial request for 97110, therapeutic exercises, 9 units was non-certified on 09/27/12 noting that the patient has had 60 post-op PT visits per the carrier notes. There is no updated exam by the treating doctor to assess current deficits or clinical rationale for additional PT. The claimant should be able to be transitioned to a home exercise program. The request exceeds evidence based guidelines. The denial was upheld on appeal dated 10/03/12 noting that the patient has more than exceeded ODG for this injury at 60 visits.

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 97110, therapeutic exercises, 9 units is not recommended as medically necessary. The patient underwent ORIF on 03/21/12 and has completed 60 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 30 visits of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. The patient's compliance with an active home exercise program is not documented. The patient has completed sufficient formal therapy.

IRO REVIEWER REPORT TEMPLATE -WC

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 Knee and Leg Chapter

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 **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