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Notice of Independent Review Decision

Date notice sent to all parties:

August 4, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal PT 2xwk x 8 wks right knee 97110 97002 97014 97140 97150 97116
97712 97010

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

Board Certified Orthopedic Surgeon (Joint)

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The patient states that he was kneeling down and twisted his knee as he stood up. MRI of the right knee dated 02/05/14 revealed complex tear of the body and posterior horn of the medial meniscus. He subsequently underwent right knee arthroscopic medial meniscus repair on 02/20/14. The patient completed at least 21 postoperative physical therapy visits. Follow up note dated 06/30/14 indicates that he presents with complaints of intermittent episodes of mild right anterior and right medial knee joint pain rated as 2/10. On physical examination there is no ecchymosis and no erythema. Strength is rated as 3/5 in flexion and extension. Range of motion is

improving. Lateral Apley's grind, medial Apley's grind, medial and lateral McMurray tests are negative. Sensation is intact.

Initial request for physical therapy 2xwk x 8 wks right knee 97110 97002 97014 97140 97150 97116 97712 97010 was non-certified on 06/04/14 noting that the request for additional therapy exceeds guideline recommendations and more than 4 modalities/procedures were recommended on the request. The denial was upheld on appeal dated 06/23/14 noting that the patient's postoperative therapy has exceeded guideline recommendations. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. The request includes CPT codes 97014 and 97010. Official Disability Guidelines recommend active modalities for physical therapy 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 2xwk x 8 wks right knee 97110 97002 97014 97140 97150 97116 97712 97010 is not recommended as medically necessary. The patient underwent right knee arthroscopic medial meniscus repair on 02/20/14 and has completed at least 21 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 12 sessions 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. ODG notes that no more than 3-4 modalities should be performed per visit, and ODG does not support the utilization of modalities 97014 and 97010. 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:

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) Knee bracing after ACL reconstruction appears to be largely useless, according to a systematic review. The most important rehab for ACL surgery patients is to start physical therapy early and rigorously. Accelerated rehabilitation (starting at 3 weeks postoperatively rather than the traditional 3 months and intended to reduce the usual 6-month time for return to activity) was considered to be safe according to this review. The authors conclude that immediate postoperative weight-bearing, range of knee motion from 0° to 90° of flexion, and strengthening with closed-chain exercises are likely to be safe. They also suggest that starting eccentric quadriceps strengthening and isokinetic hamstring strengthening at week 3 after surgery may accelerate recovery. The reviewers found promising data for home-based rehabilitation for the motivated patient, but found doubtful support for neuromuscular training such as proprioceptive and balance training, perturbation training, and vibratory stimulation. (Kruse, 2012) See specific physical therapy modalities by name, as well as Exercise. See also Aerobic exercises; 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); Education; Electrical stimulators (E-stim); 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; Heat; Home exercise kits; Immobilization; Interferential current stimulation (ICS); Iontophoresis; Joint active systems (JAS) splints; Joint mobilization; Kinesio tape (KT); Knee brace; Low level laser therapy (LLLT); Magnet therapy; Manipulation; Manual therapy; Massage therapy; Mechanical

stretching devices (for contracture & joint stiffness); Mud pack therapy; Non-surgical intervention for PFPS (patellofemoral pain syndrome); Orthoses; Phonophoresis; Power mobility devices (PMDs); Proprioception exercises; Pulsed magnetic field therapy (PMFT/PEMF); Static progressive stretch (SPS) therapy; Strapping; Strengthening exercises; Stretching and flexibility; Tai Chi; Taping; Therapeutic knee splint (patellofemoral pain); Traction, knee (skeletal traction treatment); Ultrasound, therapeutic; U-Step walker; 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). This systematic review concluded that PT interventions that empower patients to actively self-manage knee OA (such as aerobic, strength, and proprioception exercise) improved outcomes the best. (Wang, 2012) The latest AAOS Guidelines for Treatment of Osteoarthritis of The Knee, include a strong recommendation that patients with symptomatic osteoarthritis of the knee participate in self-management programs, strengthening, low-impact aerobic exercises, and neuromuscular education; and engage in physical activity consistent with national guidelines. (AAOS, 2013)

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):

Medical treatment: 9 visits over 8 weeks

Post-surgical: 12 visits over 12 weeks

Articular cartilage disorder - chondral defects (ICD9 718.0)

Medical treatment: 9 visits over 8 weeks

Post-surgical (Chondroplasty, Microfracture, OATS): 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):

Medical treatment: 10 visits over 8 weeks

Post-surgical (closed): 10 visits over 8 weeks

Post-surgical treatment (ORIF): 30 visits over 12 weeks

Fracture of tibia and fibula (ICD9 823)

Medical treatment: 12-18 visits over 8 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