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Notice of Independent Review Decision

Date notice sent to all parties:

December 30, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions of physical therapy

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

Board Certified PM&R; Board Certified Pain Medicine

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
MRI lumbar spine dated 07/03/13
Office note dated 08/02/13, 08/07/13, 10/10/13, 09/26/13, 09/12/13, 08/29/13, 08/19/13, 08/15/13
Physical therapy re-evaluation dated 08/06/13
Physical therapy daily note dated 08/06/13, 08/09/13, 08/12/13
Handwritten note dated 11/01/13
Initial physical examination dated 11/01/13
Appeal letter dated 11/14/13, 11/21/13
Prior review dated 11/11/13, 11/20/13

EMG/NCV dated 11/19/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient torqued her back while turning. MRI of the lumbar spine dated 07/03/13 revealed at L5-S1 desiccation and loss of normal water content; 2 mm ventral bulging disc; borderline spinal stenosis; AP dimension of the bony spinal canal narrowed to 10 mm; no lateralized defect nor focal disc herniations. Per follow up note dated 08/07/13, diagnoses are bilateral neck sprain and bilateral thoracic sprain. The patient subsequently completed 18 physical therapy visits. Initial examination dated 11/01/13 indicates that the patient presents with neck, low back and left knee pain rated as 9/10. On physical examination cervical range of motion is flexion 30, extension 40, bilateral lateral flexion 25 and bilateral rotation 60 degrees. Lumbar range of motion is flexion 20, extension 5, bilateral lateral flexion 10 degrees. Left knee range of motion is extension 5, flexion 100 degrees. Strength is rated as 5/5 in the right lower extremity and 4-/5 left lower extremity. Straight leg raising is noted to be positive bilaterally. Apprehension test for the patella is positive on the left and Lachman's test is positive on the left. Diagnoses are listed as neck sprain, lumbar sprain and sprain of unspecified site of knee and leg. EMG/NCV dated 11/19/13 revealed moderate left and mild to moderate right carpal tunnel syndrome; and lumbar radiculopathy involving the L5 nerve roots bilaterally.

Initial request for 12 sessions of physical therapy was non-certified on 11/11/13 noting that the ODG guidelines allow for up to 10 visits of physical therapy over 8 weeks. In this case, the records reflect that the patient has completed 18 PT sessions, already exceeding the guideline recommendations. Moreover, the 11/01/13 report does not demonstrate that the patient is unable to participate in a self-directed home exercise program as would be expected at this juncture. The denial was upheld on appeal dated 11/20/13 noting that the objective and functional outcomes of the previous 18 PT sessions have not been discussed in detail. Furthermore, as noted by the initial peer reviewer, the claimant has far exceeded the ODG best practice guidelines, which are 10 sessions for lumbar sprain/strain and 12 sessions for knee sprain/strain. There is limited evidence of an exceptional factor to warrant further supervised therapy beyond the completed 18 PT sessions. The claimant is expected to be independent in a home exercise program by this time. Appeal letter dated 11/21/13 indicates that the patient believes her condition will worsen with time.

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 is not recommended as medically necessary. Diagnoses are listed as neck sprain, lumbar sprain and sprain of unspecified site of knee and leg. The patient has completed 18 physical therapy visits to date. The Official Disability Guidelines support up to 10 visits of physical therapy for neck sprain, 10 visits for lumbar

sprain, and 12 visits for sprain of knee and leg, and there is no clear rationale provided to support continuing to exceed these recommendations. 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:

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Low Back Chapter

Physical therapy (PT)

Recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. See also Exercise. Direction from physical and occupational therapy providers can play a role in this, with the evidence supporting active therapy and not extensive use of passive modalities. The most effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle-strengthening exercises seem to be the most effective types of exercises for treating chronic low back pain. (Hayden, 2005) Studies also suggest benefit from early use of aggressive physical therapy ("sports medicine model"), training in exercises for home use, and a functional restoration program, including intensive physical training, occupational therapy, and psychological support. (Zigenfus, 2000) (Linz, 2002) (Cherkin-NEJM, 1998) (Rainville, 2002) Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. (Mannion, 2001) (Jousset, 2004) (Rainville, 2004) (Airaksinen, 2006) One clinical trial found both effective, but chiropractic was slightly more favorable for acute back pain and physical therapy for chronic cases. (Skargren, 1998) A spinal stabilization program is more effective than standard physical therapy sessions, in which no exercises are prescribed. With regard to manual therapy, this approach may be the most common physical therapy modality for chronic low back disorder, and it may be appropriate as a pain reducing modality, but it should not be used as an isolated modality because it does not concomitantly reduce disability, handicap, or improve quality of life. (Goldby-Spine, 2006) Better symptom relief is achieved with directional preference exercise. (Long, 2004) As compared with no therapy, physical therapy (up to 20 sessions over 12 weeks) following disc herniation surgery was effective. Because of the limited benefits of physical therapy relative to "sham" therapy (massage), it is open to question whether this treatment acts primarily physiologically, but psychological factors may contribute substantially to the benefits observed. (Erdogmus, 2007) In this RCT, exercise and stretching, regardless of whether it is achieved via yoga classes or conventional PT supervision helps improve low back pain. (Sherman, 2011) See also specific physical therapy modalities, as well as Exercise; Work conditioning; Lumbar extension exercise equipment; McKenzie method; Stretching; & Aquatic therapy. [Physical therapy is the

treatment of a disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, activities of daily living and alleviating pain. (BlueCross BlueShield, 2005) As for visits with any medical provider, physical therapy treatment does not preclude an employee from being at work when not visiting the medical provider, although time off may be required for the visit.]

Active Treatment versus Passive Modalities: The use of active treatment instead of passive modalities is associated with substantially better clinical outcomes. In a large case series of patients with acute low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) 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). A recent RCT comparing active spinal stabilization exercises (using the GDS or Godelive Denys-Struyf method) with passive electrotherapy using TENS plus microwave treatment (considered conventional physical therapy in Spanish primary care), concluded that treatment of nonspecific LBP using the GDS method provides greater improvements in the midterm (6 months) in terms of pain, functional ability, and quality of life. (Arribas, 2009) In this RCT, two active interventions, multidisciplinary rehab (intensive, bio-psychosocial PT) and exercise (exercises targeted at trunk muscles together with stretching and relaxation), reduced the probability of sickness absence, and were more effective for pain than self-care advice at 12 months. (Rantonen, 2012)

Patient Selection Criteria: Multiple studies have shown that patients with a high level of fear-avoidance do much better in a supervised physical therapy exercise program, and patients with low fear-avoidance do better following a self-directed exercise program. When using the Fear-Avoidance Beliefs Questionnaire (FABQ), scores greater than 34 predicted success with PT supervised care. (Fritz, 2001) (Fritz, 2002) (George, 2003) (Klaber, 2004) (Riipinen, 2005) (Hicks, 2005) Without proper patient selection, routine physical therapy may be no more effective than one session of assessment and advice from a physical therapist. (Frost, 2004) Patients exhibiting the centralization phenomenon during lumbar range of motion testing should be treated with the specific exercises (flexion or extension) that promote centralization of symptoms. When findings from the patient's history or physical examination are associated with clinical instability, they should be treated with a trunk strengthening and stabilization exercise program. (Fritz-Spine, 2003) Practitioners must be cautious when implementing the wait-and-see approach for LBP, and once medical clearance has been obtained, patients should be advised to keep as active as possible. Patients presenting with high fear avoidance characteristics should have these concerns addressed aggressively to prevent long-term disability, and they should be encouraged to promote the resumption of physical activity. (Hanney, 2009)

Post Epidural Steroid Injections: ESIs are currently recommended as a possible option for short-term treatment of radicular pain (sciatica), defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The general goal of physical therapy during the

acute/subacute phase of injury is to decrease guarding, maintain motion, and decrease pain and inflammation. Progression of rehabilitation to a more advanced program of stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based research that addresses the use of physical therapy post ESIs, but it appears that most randomized controlled trials have utilized an ongoing, home directed program post injection. Based on current literature, the only need for further physical therapy treatment post ESI would be to emphasize the home exercise program, and this requirement would generally be included in the currently suggested maximum visits for the underlying condition, or at least not require more than 2 additional visits to reinforce the home exercise program. ESIs have been found to have limited effectiveness for treatment of chronic pain. The claimant should continue to follow a home exercise program post injection. (Luijsterburg, 2007) (Luijsterburg2, 2007) (Price, 2005) (Vad, 2002) (Smeal, 2004)

Post-surgical (discectomy) rehab: A recent Cochrane review concluded that exercise programs starting 4-6 weeks post-surgery seem to lead to a faster decrease in pain and disability than no treatment; high intensity exercise programs seem to lead to a faster decrease in pain and disability than low intensity programs; home exercises are as good as supervised exercises; and active programs do not increase the re-operation rate. Although it is not harmful to return to activity after lumbar disc surgery, it is still unclear what exact components should be included in rehabilitation programs. High intensity programs seem to be more effective but they could also be more expensive. Another question is whether all patients should be treated post-surgery or is a minimal intervention with the message return to an active lifestyle sufficient, with only patients that still have symptoms 4 to 6 weeks post-surgery requiring rehabilitation programs. (Ostelo, 2009) There is inconclusive evidence for the effectiveness of outpatient physical therapy after first lumbar discectomy. Although evidence from two trials suggested that intervention might reduce disability short-term, and more intensive intervention may be more beneficial than less intensive therapy, pooled results did not show statistically significant benefit. (Rushton, 2011) A systematic review yielded moderate to low quality evidence for effectiveness of postoperative exercise programs starting 4-6 weeks after lumbar disc surgery. Exercise programs seem to be more beneficial than no treatment, and high intensity exercises may be more effective than low intensity exercises. (Oosterhuis, 2013)

Post-surgical (fusion) rehab: Following lumbar spinal fusion, delayed start of rehabilitation results in better outcomes, and improvements in the group starting at 12-weeks were 4 times better than that in the 6-week group. (Oestergaard, 2012)

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more 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, including assessment after a "six-visit clinical trial".

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):

10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846):

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5):

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

Intervertebral disc disorder with myelopathy (ICD9 722.7)

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis (ICD9 724.0):

10 visits over 8 weeks

See 722.1 for post-surgical visits

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):

10-12 visits over 8 weeks

See 722.1 for post-surgical visits

Curvature of spine (ICD9 737)

12 visits over 10 weeks

See 722.1 for post-surgical visits

Fracture of vertebral column without spinal cord injury (ICD9 805):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury (ICD9 806):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Work conditioning (See also Procedure Summary entry):

10 visits over 8 weeks

ODG Neck and Upper Back Chapter

Physical therapy (PT)

Recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider, to avoid debilitation and further restriction of motion. (Rosenfeld, 2000) (Bigos, 1999) For mechanical disorders for the neck, therapeutic exercises have demonstrated clinically significant benefits in terms of pain, functional restoration, and patient global assessment scales. (Philadelphia, 2001) (Colorado, 2001) (Kjellman, 1999) (Seferiadis, 2004) Physical therapy seems to be more effective than general practitioner care on cervical range of motion at short-term follow-up. (Scholten-Peeters, 2006) In a recent high quality study, mobilization appears to be one of the most effective non-invasive interventions for the treatment of both pain and cervical range of motion in the acutely injured WAD patient. (ConlinI, 2005) A recent high quality study found little difference among conservative whiplash therapies, with some advantage to an active mobilization program with physical therapy twice weekly for 3 weeks. (Kongsted, 2007) See also specific physical therapy modalities, as well as Exercise.

ODG Physical Therapy 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, including assessment after a "six-visit clinical trial".

Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0):

9 visits over 8 weeks

Sprains and strains of neck (ICD9 847.0):

10 visits over 8 weeks

Displacement of cervical intervertebral disc (ICD9 722.0):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (fusion, after graft maturity): 24 visits over 16 weeks

Degeneration of cervical intervertebral disc (ICD9 722.4):

10-12 visits over 8 weeks

See 722.0 for post-surgical visits

Brachia neuritis or radiculitis NOS (ICD9 723.4):

12 visits over 10 weeks

See 722.0 for post-surgical visits

Post Laminectomy Syndrome (ICD9 722.8):

10 visits over 6 weeks

Fracture of vertebral column without spinal cord injury (ICD9 805):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury (ICD9 806):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Work conditioning (See also Procedure Summary entry):

10 visits over 8 weeks

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