

Vanguard MedReview, Inc.

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Notice of Independent Review Decision

October 7, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3 x week x 6 weeks Left Knee

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

This reviewer is a Board Certified Orthopedic Surgeon with over 42 years of experience.

REVIEW OUTCOME:

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

Overturned (Disagree)

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 claimant is a male who was injured at work on xx/xx/xx when the xxxxx, resulting in a fall.

: CT of the abdomen and CT of the pelvis. **Impression:** No acute finding. Bilateral parapelvic cysts and benign-appearing renal cysts. No acute visceral, vascular injury or abnormal fluid collection. No acute fracture involving the abdominal or pelvic structures.

CT lumbar spine. **Impression:** No acute finding

CT Thoracic spine. **Impression:** No acute finding

: X-Ray Wrist interpreted by. **Impression:** Comminuted and impacted and angulated fractures of the distal shaft of both radii.

: Consultation. **HPI:** Patient has history of diabetes, cataracts, and went to xxx. He was found to have an open left femur fracture for which he is now status post ORIF on xxx. He also had bilateral distal radius fractures and is status post closed reduction on 5/12/15. Nasal fracture surgery was done fracture repairs were done. Femur fracture repair was done. Prior to admission, the patient was independent with mobility and self-care. Currently,

is on a PCA pump. The patient thus far is ambulating 150 feet with EVA walker. He appears very motivated for therapy and regaining functional status. **Physical Exam:** The patient is able to wiggle his fingers and toes bilaterally. He has 5/5 strength diffusely in the right lower extremity. He has antigravity shoulder abduction and flexion bilaterally. Musculoskeletal: Does not appear to be any focal muscle atrophy. Extremities: He does have swelling essentially in all distal extremities. He does have functional ROM in bilateral upper extremities.

Rehabilitation Assessment and plan: 1. Left femur fracture, status post open reduction and internal fixation. 2. Bilateral distal radius fracture, status post closed reduction on May 12. 3. Nasal fracture and laceration, status post repair. 4. The patient is non weight bearing left lower extremity and platform weight bearing bilateral upper extremities. The patient is appropriate for inpatient rehab for 3 hours of therapy a day for physical therapy and occupational therapy. We will plan to admit the patient once deemed medically appropriate by and the ortho service. I would like to see the patient off his PCA pump and tolerating his pain prior to movement to rehabilitation. I am also going to order a speech therapy evaluation for cognitive evaluation as the patient did xxxxx. I do not suspect any significant cognitive deficits, but I would like more in depth evaluation.

: Maxillofacial, Bones. **Impression:** Comminuted nasal bone fracture

: CT Cervical Spine. **Impression:** No acute fracture or subluxation. Cervical spondylosis at C5-C6

05/12/2015: I & D, External Fixator Femur. **Pre-procedure diagnosis:** L open SCF fx, L closed DR fx, R closed DR fx

05/18/2015: ORIF Left Femur FX, Removal External Fixator L knee by, DO. **Pre-procedure diagnosis:** Open L SC/IC distal femur fx

05/21/2015: Progress Note. **Subjective:** Patient states his pain overall controlled. He is moving his bowels.

Objective: In no acute distress, alert. **Plan:** 1. Left femur fracture 2. Bilateral radius fracture. 3. Facial fracture. The patient has done well therapy. Overall, he has now achieved all of his inpatient rehabilitation goal. He is modified independent level with bed mobility, transfers, and post self-care tasks. He had a modified independent level with wheelchair mobility, and able to flex his knee to approximately 55° actively. His left lower extremity staples are all out. Anesthesia incision is healing. After family training has completed tomorrow the patient will be ready for discharge.

06/08/2015: Office Visit. **HPI:** Patient presents s/p ORIF L SCF fracture with plate and screws. Also sustained L and R DR Fx's. All injuries sustained while at work on. He underwent ORIF L femur on 5/12/15. Present in WC and accompanied by. Reports not taking pain meds. Had staples removed during PT. Progressing well. The plan called for conservative treatment of b/l wrist fractures. **Exam:** Right wrist: tenderness on palpation of volar aspect of right wrist-No tenderness on palpation of radial aspect of right wrist; no tenderness on palpation of ulnar aspect of right wrist. ROM: active flexion of right wrist; active extension of right wrist; wrist pain elicited throughout ROM case observations: Right wrist immobilized in case/splint. Unable to bend wrist due to cast immobilization; flexion of wrist abnormal; wrist weakness. Sensation: no decreased response to tactile stimulation on right hand; no decreased response to tactile stimulation on hand on dorsal of radial 3-1/2 digits; no decreased response to tactile stimulation on hand of ulnar 1-1/2 digits; sensation intact for light touch; no decreased position sensory response at level of wrist. Left Wrist: ROM: active flexion of left wrist; active extension of left wrist; active motion of left wrist decreased. Able to straighten and bend wrist. Wrist weakness. no decreased response to tactile stimulation on hand on dorsal of radial 3-1/2 digits; no decreased response to tactile stimulation on hand of ulnar 1-1/2 digits; sensation intact for light touch; no decreased position sensory response at level of wrist. **Plan:** 1. NWB LLE x 12 weeks 2. SAC x 10 days, b/l 3. PT Rx given 4. RTC in 10 days for SAC removal and start OT 5. Cont finger AROM.

08/13/2015: UR. **Rationale for Denial:** The date of injury is xx/xx/xx. The patient has multiple complaints, including left knee pain. There were fractures of the left femur, bilateral wrists and nose. The injury occurred when the patient xxxxx. The patient underwent open reduction internal fixation of left femur on 5/19/15. Requested were 18 sessions of therapy. The patient has attended 15 days inpatient rehab, 24 sessions of physical therapy and 3 sessions of occupational therapy of therapy to date. The physical therapy reevaluation of 7/23/15 shows ROM to remain poor with active ROM and passive ROM varying from each other by only a few degrees.

Adhesive capsulitis should be considered. Strength has also failed to recover. There are no objective indications of progressive, clinically significant improvement from prior therapy. Continuation of therapy should be predicated on a formal assessment validating improvement in function at intervals of 6 sessions. Furthermore, part of this request includes a list of proposed modalities or numbers of units (up to 6 modalities/units per session were requested). There is no adequate explanation as to why more than 3 to 4 modalities/procedural units per session would be indicated. Generally, there should be no more than 4 modalities/procedural units in total per visit, allowing the physical therapy (PT) visit to focus on those treatments where there is evidence of functional improvement, and limiting the total length of each PT visit to 45-60 minutes unless additional circumstances exist requiring extended length of treatment. Treatment times per session may vary based upon the patient's medical presentation but typically may be 45-60 minutes in order to provide full, optimal care to the patient. Additional time may be required for the more complex and slow to respond patients. While an average of 3 or 4 modalities/procedural units per visit reflect the typical number of units, this is not intended to limit or cap the number of units that are medically necessary for a particular patient, for example, in unusual cases where comorbidities involve completely separate body domains, but documentation should support an average greater than 4 units per visit. These additional units should be reviewed for medical necessity, and authorized if determined to be medically appropriate for the individual injured worker" (see ODG) The available clinical information does not support that the request is medically reasonable and necessary. The medical necessity of this request is non certified.

08/21/2015: Reconsideration Request is a highly motivated patient who shows his concern for his well-being by attending his appointments promptly & consistently, by being compliant with his home exercise routine, and by keeping his enthusiasm during his PT sessions came to PT on 6/19/15 on a platform walker and unable to bear weight on his (L) LE because of the contraindications from his severe trauma & multiple fractures to his femur & knee. Upon his first session, he only had 40° of total ROM in his knee, moderate edema, and severe weakness throughout his (L) LE. Over the next 30 days did everything we and the MD asked of him. We knew coming into the PT he was going to need months of rehab to reach his prior level of function. Maximum therapeutic benefit would be months off with the expectation of slow progress because of not only his complicated surgeries & complex injures; but, also because of his Diabetes. Upon his re-evaluation on 7/23/15, made great strides to reach 60° of total ROM in knee. Again, we knew this was going to be a struggle since he was unable to bear weight which always helps increase neuromuscular control, muscle power, and ROM. He was able to reach many functional goals because of his inability to bear weight. However, he still managed to reach 40% of the goals set at the initial evaluation. At 30 days, we are supposed to perform a full re-evaluation; but, we learned he was denied more visits before the 30 day mark. However, he has recently begun to bear weight through (L) LE which has helped him make tremendous improvements. He is now able to bend his knee at least 90° which allows him to get on the bike & make full revolutions. He is now able to bear weight & start other resisted activities such as the leg press so that he can rise from sit to stand without assistance. In addition, he is now able to walk with a cane & drive his own car. has made great progress thus far but he is many months away from being at his prior levels of function. This denial is not appropriate based on his comorbidities, complexity of his injury, and his compliance with his healthcare deserves proper treatment and care in order to reach normal function and return to work. Please, reconsider his case and extend his physical therapy until he reaches maximum therapeutic benefit.

09/03/2015: UR. **Rationale for Denial:** The patient has multiple complaints, including left knee pain. There were fractures of the left femur, bilateral wrists and nose. The injury occurred when the patient xxxxxx. The patient underwent open reduction internal fixation of left femur on 5/19/15. Requested were 18 sessions of therapy. The patient has attended 15 days inpatient rehab, 24 sessions of physical therapy and 3 sessions of occupational therapy of therapy to date. The physical therapy reevaluation of 7/23/15 shows ROM to remain poor with active ROM and passive ROM varying from each other by only a few degrees. On 8/5/15, there was active flexion of 79° and passive flexion of 90 and the patient has begun weight bearing. The therapist argues that the starting point was so poor, that the patient should be allowed additional visits beyond the maximum specified in the guidelines. Furthermore, passive ROM is continuing to improve, though active ROM has only improved slightly over the past month. Furthermore, part of this request includes a list of proposed modalities or numbers of units (up to 6 modalities/units per session were requested). There is no adequate explanation as to why more than 3 to 4

modalities/procedural units per session would be indicated. Generally, there should be no more than 4 modalities/procedural units in total per visit, allowing the physical therapy (PT) visit to focus on those treatments where there is evidence of functional improvement, and limiting the total length of each PT visit to 45-60 minutes unless additional circumstances exist requiring extended length of treatment. Treatment times per session may vary based upon the patient's medical presentation but typically may be 45-60 minutes in order to provide full, optimal care to the patient. Additional time may be required for the more complex and slow to respond patients. While an average of 3 or 4 modalities/procedural units per visit reflect the typical number of units, this is not intended to limit or cap the number of units that are medically necessary for a particular patient, for example, in unusual cases where co-morbidities involve completely separate body domains, but documentation should support an average greater than 4 units per visit. These additional units should be reviewed for medical necessity, and authorized if determined to be medically appropriate for the individual injured worker per ODG. Therefore, this request is not medically necessary.

09/10/2015: Office Visit. **HPI:** Patient presents s/p ORIF L SCF fracture with plate and screws. Also sustained L and R DR Fx's. Present in WC and accompanied by wife and daughter. Reports is taking pain meds. Had staples removed during PT. Progressing well. The plan called for conservative treatment of b/f wrist fractures. OT No c/o's pain with WB. Trauma to wrist, trauma to hip(s), trauma to leg. Exacerbating factors: pain elicited by motion of wrist, pain elicited by hip motion; pain elicited by motion of knee. **Physical Exam:** Left knee: active flexion of left knee 85° normal; active extension of left knee 5° normal; motion of first toe normal. **Assessment** old male s/p ORIF L open distal femur fx s/p ORIF and closed conservative tx of B distal radius fractures. **Plan:** 1. BUE WBAT 2. LLE WBAT 3. Ambulate with a cane. 4. New PT order for LLE with restrictions given and BUE. 5. RTC 6 W w 2 views of L knee and L femur.

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

The previous adverse determinations are overturned. Because of the severity of his left leg injury, including femoral fx and surgery, loss of range of motion of his left knee, and his improvement with his physical therapy and rehabilitation, it would be my opinion that further physical therapy, (Physical Therapy 3 x week x 6 weeks Left Knee) is indicated. This therapy should specifically be aimed at rehabilitation of his left leg including strength and knee range of motion.

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):

Medical treatment: 18 visits over 8 weeks

Post-surgical treatment: 24 visits over 10 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

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)