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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Outpatient Physical Therapy to Right Knee 8 visits

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: American Board Certified Physician in Physical Med. and Rehab with over 20 years' experience.

REVIEW OUTCOME:

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

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]: Patient sustained a work injury in XX/XXXX. She is status post XX/XX/XX right knee arthroscopy with partial lateral meniscectomy. Eighteen postoperative physical therapy sessions have been authorized to date. Pt is still having knee pain and edema, pain mostly in the lateral aspect of the knee. Request is for additional physical therapy for her knee pain.

XX/XX/XX: H&P Report #5: This is a female who presents for a recheck of right knee pain. Date of Injury XX/XX/XX. This patient is a week status post arthroscopy of her right knee with partial lateral meniscectomy. She had a bipartite patella, which was our decision to take out, and what we did took out the area we could see arthroscopically up to where the suture line disappeared and it became one piece of bone again, one congruent patella. Apparently she was doing well and she fell today while getting up and going to the bathroom. She went to the ER and they x-rayed her and the x-rays were negative and she came in to see me for further evaluation. Physical Exam: Right lower extremity- On exam today, as far as the knee goes, it feels stable to varus and valgus stress. It is difficult to assess the anterior and posterior stability. She has a noted joint effusion. The Incisions look good. There are no signs of infection. She has pain with attempted ROM. At this point I am going to put her in a hinged knee brace on the right side and get her in some formal therapy.

XX/XX/XX: H&P Report #6: On exam today, her knee looks good. She said it hurts, but she cannot localize it to a specific point. Her ROM has improving. She has a minimal joint effusion. At this point I think therapy is warranted. We will continue aggressive physical therapy and I will see her back in 4 weeks. We will keep her off work for now.

XX/XX/XX: H&P Report #7: On exam today, pt has very little crepitus with ROM of the knee. She has no pain with McMurray's in the knee. The knee is stable to exam, so I think a lot of this is just post-surgery pain. I think continued therapy is warranted. I encouraged her to progress activities as tolerated and will see her back in 6 weeks.

XX/XX/XX: IRO: Rationale: Outpatient physical therapy to the right knee, two times a week for four weeks, consisting of gait training, neuromuscular re-education, therapeutic exercises, therapeutic activities, manual

therapy, group therapeutic therap, electrical stimulation, ultrasound, and hot and cold packs. Claimant has completed a course of postoperative physical therapy exceeding ODG recommendations and appears to have plateaued with skilled therapy. Based upon the available documentation, medical necessity is not established for additional skilled therapy beyond evidence-based recommendations. In addition, this request includes passive modalities (ultrasound and therapist administered electrical stimulation) which are not recommended by ODG for this condition.

XX/XX/XX: Sports Medicine & Rehab Ongoing Plan of Care: Assessment: PT is still having fairly high discomfort in the knee with activity. Walking with pain, still wearing knee brace. Also pt is limited with advancing exercises due to pain, unable to squat, stoop or climb stairs, steps and ladders which are work related type movements she has to do for work. Pain levels are high 6-9/10 most days in therapy being reported. Pt complains of knee giving way more daily now with pain. There is a palpable fluid sack/hard tissue noted in the popliteal region of the knee today as well. Pt desires to return to work activities as listed above, but had some set back during therapy with pain and therapeutic exercise advancement due to there was noted weakness in the quadriceps muscles, which is important for patient to be able to appropriately perform and complete job tasks, such as climbing ladders and stairs on a daily basis. This muscle aides in lifting the body up and lowering with ascending and descending steps/stairs/ladders. Strength to the knee 4/5 ROM is WFL 3-120 degrees but with pain in flexion motion. Pain levels 6-8/10 most therapy days being reported. Anterior knee region mostly. Recommendations to continue with 3 x a week for 3 weeks of therapy per referral.

XX/XX/XX: H&P Report #8: I repeated some radiographs, three views of the knee which shoes the incompletely excised bipartite patella and some degenerative changes mainly in that lateral compartment with some joint space narrowing

XX/XX/XX: H&P Report #9: On exam today, there is no pain over the lateral aspect of the patella. She has a negative grind test. She has full extension. She has good overall flexion limited by the joint effusion. There is no pain with McMurray's there are no palpable masses. There are no radicular symptoms. We discussed treatment options. Her big problem now is she feels tight in the back part of her knee and she gets swelling in the knee. At this point, I am going to keep her on anti-inflammatory. We are going to continue physical therapy and we will proceed with cortisone injections in the right knee and I will see her back in 6 weeks. If there is no improvement in 6 weeks then I think visco supplementation injections are an option at that time.

XX/XX/XX: IRO: Rationale: Rationale for continued PT is no seen. Claimant should be on home exercise at this point.

XX/XX/XX: Patient Care Plan Note: Instructions: Activities as tolerated. You are not allowed to accept Rx for pain medication. It is in violation of the CSA, Advised on strengthening exercise and ROM exercise. Follow up in 4 weeks (This patient continues to have severe inflammation in the operative knee. Pain persists. A bakers Cyst has developed which was responsive to intra-articular injection. Physical therapy would be beneficial to increase ROM in the operative knee. Patient continues to follow with the surgeon for post-operative intra-articular injections. Patient may respond to further corticosteroid injections or she may require synvisc injection. Patient has not reached full potential at this point in my opinion.)

XX/XX/XX: Office Note: We are following this patient for arthroscopy of her knee back in XX. We did a partial lateral meniscectomy. We resected part of a bipartite patella, here to follow up. She is still having pain. She claims the injections did help, but she is still having discomfort and swelling. She localizes most of the pain laterally, down the anterior compartment of the leg and then up right in the lateral aspect of the knee. On exam today, the knee looks better than what is has looked. It does not have as much swelling though there is a joint effusion. She has no real joint line tenderness. She has pain with hyperflexion probably greater than about 110 to 115 degrees. She has some mild pain with McMurray's. There is no instability. There are no radicular symptoms. There are no palpable masses. There is no pain over the patella itself. We have discussed treatment options. We know she has some posttraumatic arthritis in her knee- at this point in time, my recommendation is let us continue the anti-inflammatory that XX has put her on and let us get the Visco injections approved. I think 8 more sessions of therapy is warranted. Early on the therapy was not helpful for her because she was having so much discomfort, so I think another round of therapy

would be beneficial for her. I will see her back when the visco injections have been approved. I do not think she is a MMI at this time.

XX/XX/XX: Patient Care Plan Note: Continued Therapy to focus more on work related tasks of climbing stairs, ladders, and quadriceps strengthening would benefit XX. Possible Job performance would be affected as she will likely have limitations with her regular duties. Performing high demand activities on a Limb that is weakened and painful can result in further injury to the same area or other areas of the body from compensation. Possible FCE could be performed or recommend work conditioning or a work hardening program for this patient.

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

Determination: denial of additional 8 PT visits is UPHELD/AGREED UPON since the request exceeds ODG recommended number of visits for submitted diagnosis, and clinically, after reported completion of 18 post-op visits, there is documented full knee range of motion, documented pending invasive procedures (steroid and/or visco supplementation injections) which may change the rehabilitation treatment plan, and documented consideration of progression to more functional rehabilitation programs (work conditioning or work hardening). Therefore, Outpatient Physical Therapy to Right Knee 8 visits is not medically necessary.

Per ODG:

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

Criteria for admission to a Work Hardening (WH) Program:

(1) *Prescription*: The program has been recommended by a physician or nurse case manager, and a prescription has been provided.

(2) *Screening Documentation*: Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.

(3) *Job demands*: A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).

(4) *Functional capacity evaluations (FCEs)*: A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.

(5) *Previous PT*: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.

(6) *Rule out surgery*: The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).

(7) *Healing*: Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.

(8) *Other contraindications*: There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.

(9) *RTW plan*: A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.

(10) *Drug problems*: There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.

(11) *Program documentation*: The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should be documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.

(12) *Further mental health evaluation*: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.

(13) *Supervision*: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.

(14) *Trial*: Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.

(15) *Concurrently working*: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.

(16) *Conferences*: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.

(17) *Voc rehab*: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.

(18) *Post-injury cap*: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see [Chronic pain programs](#)).

(19) *Program timelines*: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.

(20) *Discharge documentation*: At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.

(21) *Repetition*: Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

ODG Work Conditioning (WC) Physical Therapy Guidelines

WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug

or attitudinal barriers to recovery not addressed by these programs). See also [Physical therapy](#) for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.
Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

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)