

INDEPENDENT REVIEWERS OF TEXAS, INC.

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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional physical therapy for 2-3 times a week for 4 weeks

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

MD, 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XXXX whose date of injury is XXXX. The patient XXXX, on XXXX left leg. The patient sustained an ankle fracture and tibia plateau fracture with bone graft and ORIF bimalleolar fracture of the left ankle on XXXX. Office visit note dated XXXX indicates that the patient is walking with a walker but can do a cane. On physical examination knee range of motion is 0-110 degrees. Deep tendon reflexes are normal. Initial evaluation dated XXXX indicates that estimated current PDL is sedentary. On physical examination left knee AROM is -10 to 109 degrees. Ankle AROM is DF 7, PF 35, inversion 20 and eversion 12 degrees. Strength is 3+/5 knee extension and 3/5 knee flexion.

The initial request for additional physical therapy for 2-3 times a week for 4 weeks was non-certified noting that since the claimant has already completed 20 sessions of physical therapy from XXXX without consistent documentation of improvement in XXXX symptoms, there is a lack of sufficient medical evidence as to why the claimant is not discharged to a self-directed home-based exercise program. In addition, additional physical therapy would exceed the ODG recommendations for PT and there is a lack of clinical rationale why deviation from the guidelines is necessary. The denial was upheld on appeal noting that the patient has completed 20 physical therapy sessions since XXXX. According to the documents, there has been little evidence to indicate that the claimant has had significant improvement in range of motion, strength and functionality since the start of XXXX physical therapy. The most recent evaluation from the physical therapist on XXXX indicates a decrease in the claimant's range of motion, strength and functionality. The previous peer review documented the claimant knee demonstrated 125 degree flexion and -10 degrees extension and currently the knee flexion is 109 degrees and -10 degrees extension which is a clear regression in the claimant's range of motion and evidence that the claimant is not moving in a positive direction with physical therapy. There is no documentation of an initiation of home therapy exercises and lack of evidence to support why this has not been done. ODG recommends post-surgical ORIF physical therapy for the knee 30 visits over 12 weeks, for the ankle 21 visits over 16 weeks. The requested 12 sessions of physical therapy will exceed

the recommended sessions with no clinical evidence as to why additional sessions are necessary when the claimant is not progressing in XXXX current PT regimen.

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 additional physical therapy for 2-3 times a week for 4 weeks is not recommended as medically necessary. The patient sustained an ankle fracture and tibia plateau fracture with bone graft and ORIF bimalleolar fracture of the left ankle on XXXX. The patient has completed at least 20 postoperative physical therapy visits since XXXX. The Official Disability Guidelines would support additional physical therapy only with evidence that progress is being made. While it is noted that the Official Disability Guidelines would support up to 21 visits of physical therapy for the ankle and 30 physical therapy visits for the knee, the Official Disability Guidelines also state that while the recommendations for number of visits are guidelines and are not meant to be absolute caps for every case, they are also not meant to be a minimum requirement on each case (i.e., they are not an “entitlement”). Given the lack of significant and sustained improvement with physical therapy completed to date, medical necessity is not established and the two previous denials are upheld.

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 KNOWLEDGBASE**
- 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)**

Physical therapy (PT) Recommended.

See the Back Chapter for references.

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.

Ankle/foot Sprain:

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 34 visits over 16 weeks

Abnormality of gait:

6-48 visits over 8-16 weeks (based on specific condition)

Enthesopathy of ankle and tarsus:

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 9 visits over 8 weeks

Achilles bursitis or tendonitis:

Medical treatment: 9 visits over 5 weeks

Achilles tendon rupture:

Post-surgical treatment: 48 visits over 16 weeks

Hallux valgus:

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 9 visits over 8 weeks

Hallux varus:

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 9 visits over 8 weeks

Hallux rigidus:

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 9 visits over 8 weeks

Other hammer toe:

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 9 visits over 8 weeks

Plantar Fasciitis:

Medical treatment: 6 visits over 4 weeks

Post-surgical treatment: 10 visits over 5 weeks

Fracture of tibia and fibula:

Medical treatment: 30 visits over 12 weeks

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

Fracture of ankle:

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment: 21 visits over 16 weeks

Fracture of ankle, Bimalleolar:

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment (ORIF): 21 visits over 16 weeks

Post-surgical treatment (arthrodesis): 21 visits over 16 weeks

Fracture of ankle, Trimalleolar:

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment: 21 visits over 16 weeks

Metatarsal fracture:

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment: 21 visits over 16 weeks

Calcaneus fracture:

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment: 21 visits over 16 weeks

Fracture of one or more phalanges of foot:

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment: 12 visits over 12 weeks

Closed dislocation of ankle:

9 visits over 8 weeks

Amputation of toe:

Post-replantation surgery: 20 visits over 12 weeks

Crushing injury of ankle/foot:

Medical treatment: 12 visits over 12 weeks

Amputation of foot:

Post-replantation surgery: 48 visits over 26 weeks

Crushing injury of ankle/foot:

Medical treatment: 12 visits over 12 weeks

Arthritis (Arthropathy, unspecified):

Medical treatment: 9 visits over 8 weeks

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

Post-surgical treatment, arthroplasty/fusion, ankle: 24 visits over 10 weeks

Contusion of lower limb:

6 visits over 3 weeks

Crushing injury of lower limb:

Medical treatment: 12 visits over 12 weeks

Tarsal tunnel syndrome:

Medical treatment: 10 visits over 5 weeks

Post-surgical treatment: 10 visits over 5 weeks

Joint Disorders:

Medical treatment: 9 visits over 8 weeks

Exercise program goals should include strength, flexibility, endurance, coordination, and education. Patients can be advised to do early passive range-of-motion exercises at home by a physical therapist. See also specific physical therapy modalities by name. (Colorado, 2001) (Aldridge, 2004) This RCT supports early motion (progressing to full weight bearing at 8 weeks from treatment) as an acceptable form of rehabilitation in both surgically and nonsurgically treated patients with Achilles tendon ruptures. (Twaddle, 2007) After ankle fracture surgical fixation, commencing exercise in a removable brace or splint significantly improved activity limitation but also led to a higher rate of adverse events. Because of the potential increased risk, the patient's ability to comply with this treatment regimen is essential. (Lin, 2009) According to a Cochrane review, neuromuscular training is effective in treating chronic ankle instability. (de Vries, 2011) For patients with isolated and uncomplicated ankle fracture, a supervised exercise-based rehab program confers no additional benefits compared with advice alone, according to the randomized Exercise or Advice After Ankle Fracture (EXACT) trial. Recovery of activity limitation after ankle fracture is rapid in the first 6 months and adding passive stretch or manual therapy to a supervised exercise program does not enhance the benefits of exercise alone. In this trial rehab did not accelerate this rapid recovery. Routine care for patients after isolated ankle fracture should

include self-management advice at the time of removal of immobilization but not a supervised exercise program. (Moseley, 2015)

Active Treatment versus Passive Modalities: In general, 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).

Official Disability Guidelines Treatment Index, 23rd edition online, 2018-Knee and Leg Chapter updated 01/30/18

Physical medicine treatment Recommended as indicated below. 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 linked below. (Philadelphia, 2001)

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; Group physical therapy; 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 and 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, and walkers); Work conditioning, work hardening.

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:

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):

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:

Medical treatment: 9 visits over 8 weeks

Post-surgical: 12 visits over 12 weeks
Articular cartilage disorder - chondral defects:
Medical treatment: 9 visits over 8 weeks
Post-surgical (Chondroplasty, Microfracture, OATS): 12 visits over 12 weeks
Pain in joint; Effusion of joint:
9 visits over 8 weeks
Arthritis (Arthropathy, unspecified):
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:
9-48 visits over 8-16 weeks (based on specific condition)
Fracture of neck of femur:
Medical treatment: 18 visits over 8 weeks
Post-surgical treatment: 24 visits over 10 weeks
Fracture of other and unspecified parts of femur:
Post-surgical: 30 visits over 12 weeks
Fracture of patella:
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:
Medical treatment: 12-18 visits over 8 weeks
Post-surgical treatment (ORIF): 30 visits over 12 weeks
Amputation of leg:
Post-replantation surgery: 48 visits over 26 weeks
Quadriceps tendon rupture:
Post-surgical treatment: 34 visits over 16 weeks
Patellar tendon rupture:
Post-surgical treatment: 34 visits over 16 weeks
Hamstring strain:
Medical treatment: 12 visits over 8 weeks
Post-surgical: 24 visits over 16 weeks
Work conditioning
See Work conditioning, work hardening

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 (e.g., 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 randomized 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 re-injury, 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. Based on this 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) In this systematic review, strength training, Tai Chi and aerobics exercises improved balance and falls risk in older individuals with knee OA, while water-based exercises and light treatment did not. (Mat, 2015) For acute hamstring injury, rehabilitation (lengthening) exercises showed a significantly reduced time to return to play. (Pas, 2015)

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)