

RYCO MedReview

DATE OF REVIEW: 04/25/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy twice a week for four weeks for the cervical spine to include CPT codes 97110 and 97112

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

Licensed by the Texas State Board of Chiropractic Examiners

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An emergency room record from R.N. and Dr. (no credentials were listed) dated 12/18/06

X-rays of the cervical spine interpreted by (no credentials were listed) dated 12/18/06

A CT scan of the head and facial bones interpreted by an unknown provider (no name or signature was available) dated 12/18/06

Evaluations with D.C. dated 12/21/06, 02/16/07, and 03/19/07
Evaluations with M.D. dated 12/29/06, 01/12/07, and 02/02/07
An MRI of the cervical spine interpreted by Dr. (no credentials were listed) dated 02/01/07
A request for preauthorization from Dr. dated 02/19/07
A letter of non-certification from D.C. dated 02/23/07
A Required Medical Evaluation (RME) with M.D. dated 03/08/07
A letter of non-certification from D.C. dated 03/27/07

PATIENT CLINICAL HISTORY [SUMMARY]:

X-rays of the cervical spine interpreted by Dr. revealed a blocked vertebra at C3-C4, developmental variant and minimal facet arthritis. A CT scan of the head and facial bones interpreted by an unknown provider on 12/18/06 revealed moderate subcutaneous fat stranding in the right face with a small osteoma and minimal thickening in the maxillary antrum. On 12/21/06, Dr. requested chiropractic therapy and a possible pain management evaluation with possible MRI. On 12/29/06, Dr. recommended continued physical therapy, a TMJ injection, Skelaxin, Ibuprofen, Ambien CR, and Lorcet. On 01/12/07 and 02/02/07, Dr. performed the TMJ injection. An MRI of the cervical spine interpreted by Dr. on 02/01/07 revealed mild disc protrusions at C2 through C7. On 02/19/07 and 03/19/07, Dr. requested eight sessions of physical therapy. On 02/23/07, Dr. wrote a letter of non-authorization for the therapy. On 03/08/07, Dr. felt the patient was at Maximum Medical Improvement (MMI) with a 0% whole person impairment rating and did not require any further treatment. Dr. wrote a letter of non-authorization for physical therapy on 03/27/07.

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

Based on the review of the medical documentation, it appears this patient suffers from a condition arising from his injuries, at which time he was struck in the head and face by a large piece of wood, throwing him to the ground. The patient underwent conservative treatment in the form of passive modalities for approximately four weeks, at which time a request was submitted for progression to active therapies to assist in restoring lost range of motion, increasing joint mobility, and decreasing pain levels. That request was denied. A follow-up request was made, which in turn was also denied. Based upon the ODG PT guidelines for cervical strain, 10 visits over approximately six weeks, would fit within reason within those guidelines. Therefore, my finding is for approval for treatment to the cervical spine two times per week for four weeks, including CPT codes 97110 and 97112.

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)