



Medical Review Institute of America, Inc.  
America's External Review Network

## Notice of Independent Review Decision

DATE OF REVIEW: August 14, 2007

IRO Case #:

**Description of the services in dispute:**

Denied for medical necessity: Items PT for right wrist/hands in dispute, #97110, #97530, #97140, #97112, #97035,

**A description of the qualifications for each physician or other health care provider who reviewed the decision**

This reviewer received a Doctor of Chiropractic (DC) in 1976 and began private practice that same year. This reviewer has been performing utilization and peer reviews since 1984. In addition to multiple state licensures, this reviewer is a Licensed Insurance Consultant. This reviewer is a Diplomate of the American Board of Quality Assurance and Utilization Review Physicians (DABQAURP), Certified in Health Care Quality and Management (CHCQM). This reviewer is also a Senior Disability Analyst and Diplomate of the American Board of Disability Analysts ((D)ABDA). This reviewer has certificates of successful completion of the following courses and examinations: Utilization Review and Quality Assurance, Impairment Rating, Industrial Disability Examiner, Disability Impairment Rating, Independent Medical Examination, and Disability Evaluation. This reviewer is a National Strength and Conditioning Association Certified Strength and Conditioning Specialist, re-certified with distinction (CSCS\*D). This reviewer is also a National Strength and Conditioning Association Certified Personal Trainer, re-certified with distinction (NSCA-CPT\*D). This reviewer is also a Certified Hypnotherapist (CHt). This reviewer's private practice, five full days per week, has included the evaluation and treatment of musculoskeletal conditions, pre-

employment physical and x-ray examinations, pre-employment drug screen urine collection and submission to lab, courtesy scoliosis screens for the local schools, impairment rating, independent medical examinations, and utilization and peer review. This reviewer has been a guest speaker at the Insurance Consultant program at a major chiropractic college.

### **Review Outcome**

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

Upheld

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.

Neither ODG nor ACOEM Practice Guidelines support medical necessity for the additional requested treatment sessions using CPT code procedures #97110 (therapeutic exercises), #97530 (therapeutic activities), #97140 (manual therapy techniques), #97112 (neuromuscular reeducation), and #97035 (ultrasound).

### **Information provided to the IRO for review**

Standard case assignment form, 1 page.

CPT code descriptions for case number 1322948.1, 1 page.

Confirmation of receipt of a request for a review by an independent review organization/company request for IRO, 07/25/2007, 8 pages.

Notification of determination, 07/11/2007, 3 pages.

Notification of determination, 07/18/2007, 3 pages.

FAX cover sheet from DC, 07/12/2007, 1 page.

Narrative report from DC/ 06/25/2007, 5 pages.

Notice of assignment of independent review organization from Texas Department of Insurance, 07/27/2007, 1 page.

Narrative report from DC/, 5 pages.

Narrative report from DC/, 6 pages.

Narrative report from DC/ 12/16/2006, 7 pages.

Right wrist MRI scan report, 01/07/2007, 1 page.

EMG/NCS report from MD, 01/24/2007, 6 pages.

### **Patient clinical history (Summary)**

Per record review, experienced a work-related injury involving her right wrist/hand, right shoulder and neck while performing her normal work duties.

An initial examination/evaluation was performed by DC and DC. The diagnoses were reported as 1) median nerve neuropathy, right wrist/hand, 2) right shoulder dysfunction, R/O internal derangement, 3) cervical radiculopathy to the right - R/O HNP, and 4) right wrist/hand, right shoulder joint, and cervical spine: pain and weakness. A treatment plan of 18 sessions of physical medicine from 10/30/2006 through 12/30/2006 was recommended.

was re-examined at on 12/12/2006. had reportedly participated in 12 sessions of physical medicine to date. A treatment plan of 15 sessions of physical medicine from 12/26/2006 through 03/05/2007 was recommended.

underwent a right wrist/hand steroid injection into the Guyon's canal by , MD, on 06/25/2007.

Per report of 06/25/2007, DC, recommended 9 more sessions of physical medicine from 07/02/2007 through 08/15/2007.

### **Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.**

Neither ODG nor ACOEM Practice Guidelines support medical necessity for the additional requested treatment sessions using CPT code procedures #97110 (therapeutic exercises), #97530 (therapeutic activities), #97140 (manual therapy techniques), #97112 (neuromuscular reeducation), and #97035 (ultrasound).

For the diagnoses of sprains and strains of the wrist and hand, ODG recommends 9 physical therapy visits over 8 weeks. ODG reports in the Forearm, Wrist, & Hand (Acute & Chronic) chapter, under Procedure Summary – Forearm, Wrist, & Hand, relative to Physical/Occupational Therapy –

“ODG Physical/Occupational Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT.

Sprains and strains of wrist and hand:

9 visits over 8 weeks.”

This patient has already treated with physical therapy visits far exceeding those recommended by ODG and reportedly remains symptomatic. The records do not support medical necessity for ongoing visits exceeding those recommended by ODG.

For the diagnosis of Carpal Tunnel Syndrome, ODG recommends 1–3 physical therapy visits over 3–5 weeks, and post-surgically 3–8 visits over 3–5 weeks. ODG reports in the Carpal Tunnel Syndrome (Acute & Chronic) chapter, under Procedure Summary – Carpal Tunnel Syndrome, relative to Physical Therapy: “Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT or OT for CTS. The evidence may justify one pre-surgical visit for education and a home management program, or 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple physical therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple physical therapy office visits for recovery. Of course, these statements do not apply to cases of failed surgery and/or misdiagnosis (e.g., CRPS I instead of CTS). (Feuerstein, 1999) (O'Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006) Post surgery a home physical therapy program is superior to extended splinting. (Cook, 1995) Continued visits should be contingent on documentation of objective improvement, i.e., VAS improvement

greater than four, and long-term resolution of symptoms. Therapy should include education in a home program, work discussion and suggestions for modifications, lifestyle changes, and setting realistic expectations. Passive modalities, such as heat, iontophoresis, ultrasound and electrical stimulation, should be minimized in favor of active treatments.

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency, plus active self-directed home PT.

Medical treatment: 1–3 visits over 3–5 weeks

Post-surgical treatment (endoscopic): 3–8 visits over 3–5 weeks

Post-surgical treatment (open): 3–8 visits over 3–5 weeks.”

This patient has already treated with physical therapy visits far exceeding those recommended by ODG and reportedly remains symptomatic. The records do not support medical necessity for ongoing visits exceeding those recommended by ODG.

On page 265, ACOEM reports, “Physical modalities, such as massage, diathermy, cutaneous laser treatment, “cold” laser treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback have no scientifically proven efficacy in treating acute hand, wrist, or forearm symptoms. Limited studies suggest there are satisfying short- to medium-term effects due to ultrasound treatment in patients with mild to moderate idiopathic CTS, but the effect is not curative. Patients’ at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist.”

The physical activities and exercises recommended by ODG and ACOEM Practice Guidelines do not require ongoing licensed supervision, special equipment or a specialized facility in order to be performed.

ODG reports in the Forearm, Wrist, & Hand (Acute & Chronic) chapter, under Procedure Summary – Forearm, Wrist, & Hand, relative to exercises: “Recommend specific hand and wrist exercises for range of motion and strengthening. Patients should be advised to do early passive range-of-motion exercises at home.

Instruction in proper exercise technique is important, and a few visits to a good physical therapist can serve to educate the patient about an effective exercise program. Patients' at home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Stretching exercises as recommended by AAOS have positive, limited evidence. (Various) (Handoll–Cochrane, 2002) (Handoll, 2006) There is limited evidence that nerve and tendon gliding exercises and wrist splinting result in superior static two point discrimination compared to wrist splinting alone in the medium term.”

ODG reports in the Carpal Tunnel Syndrome (Acute & Chronic) chapter, under Procedure Summary – Carpal Tunnel Syndrome, relative to exercises: “Recommended. Recommend specific hand and wrist exercises for range of motion and strengthening. Patients should be advised to do early passive range of motion exercises at home. Instruction in proper exercise technique is important, and a few visits to a good physical therapist can serve to educate the patient about an effective exercise program. Patients' at home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Stretching exercises as recommended by AAOS have positive, limited evidence. (Various references listed under "Activity & Exercise") (Seradge) (Verhagen–Cochrane, 2004) (Baysal, 2006)(Verhagen, 2006) There is limited evidence that nerve and tendon gliding exercises and wrist splinting result in superior static two point discrimination compared to wrist splinting alone in the medium term.”

Although ODG reports, “specific hand and wrist exercises for range of motion and strengthening are recommended,” it also reports “a few visits to a good physical therapist can serve to educate the patient about an effective exercise program.” The activities recommended by ODG not require ongoing licensed supervision, special equipment or a specialized facility in order to be performed. The instructions and education provided during the numerous prior physical therapy treatment sessions at Injury Solutions – Fort Worth, should have adequately advised this patient in order that she be quite capable of performing the exercise activities supported by ODG without the need for licensed supervision, special equipment, or gym or clinic setting in order to perform the activities.

On page 265, ACOEM reports, "Instruction in home exercise. Except in cases of unstable fractures or acute dislocations, patients should be advised to do early range of motion exercises at home. Instruction in proper exercise technique is important, and a physical therapist can serve to educate the patient about an effective exercise program." This patient has already been afforded numerous physical medicine treatment sessions in which this issue should have already been adequately addressed.

On page 264, in Table 11-4, ACOEM reports under the title Physical Modalities, "Initial and follow-up visits for education, counseling, and evaluation of home exercise." Again this patient has already been afforded numerous physical medicine treatment sessions in which education, counseling, and evaluation of home exercise should have already been adequately addressed. ACOEM does not support medical necessity for ongoing licensed supervision for therapeutic exercises and therapeutic activities.

On page 83, ACOEM states, "To achieve functional recovery, patients must assume certain responsibilities. It is important that patients stay active and increase activity to minimize disuse, atrophy, aches, and musculoskeletal pain, and to raise endorphin levels. They must adhere to exercise." It is the patient's responsibility to stay active and increase activity to minimize disuse, atrophy, aches, and musculoskeletal pain, and they must adhere to exercise.

On page 117, ACOEM Practice Guidelines note, "Maintaining function will minimize the stiffness, aches, and atrophy that result from being sedentary. Typically, when function improves, so does perceived pain." Again, the patient must assume responsibilities of staying active and exercising in order to maintain function.

On pages 15 & 16 the ACOEM Practice Guidelines note, "... reconditioning and avoidance of static position for long periods of time should help to prevent recurrences. Both aerobic conditioning and conditioning of specific muscle groups (e.g., forearm muscles or neck and shoulder musculature) should reduce

the risk of future health problems.” The activities supported by ACOEM Practice Guidelines do not require ongoing licensed supervision, special equipment, or a gym or clinic setting in order to perform such activities.

Although ODG and ACOEM Practice Guidelines acknowledge that physical activity and exercise is important to the injured worker, it is ultimately the responsibility of the patient. The request for ongoing services described by CPT code procedures 97110 (therapeutic exercises) and 97530 (therapeutic activities) is not supported by ODG or ACOEM Practice Guidelines. The self-directed patient can perform a home exercise program of stretches, strengthening, stabilization, and range of motion exercises, and cardiovascular exercises, without the need for licensed supervision, special equipment, or gym or clinic setting in order to perform the activities. The self-directed patient can accomplish the activities supported by ODG and ACOEM Practice Guidelines in the privacy of their own home, performed within their tolerance and speed, without special equipment and at their convenience.

**A description and the source of the screening criteria or other clinical basis used to make the decision:**

This patient has already treated with physical therapy visits far exceeding those recommended by ODG and ACOEM Practice Guidelines, and reportedly remains symptomatic. The records do not support medical necessity for ongoing visits exceeding those recommended by ODG and ACOEM Practice Guidelines.

ODG, Forearm, Wrist, & Hand (Acute & Chronic), Procedure Summary – Forearm, Wrist, & Hand, Physical/Occupational Therapy –

“ODG Physical/Occupational Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT.

Sprains and strains of wrist and hand:

9 visits over 8 weeks.”

ODG, Carpal Tunnel Syndrome (Acute & Chronic), Procedure Summary – Carpal Tunnel Syndrome, relative to Physical Therapy:

“Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT or OT for CTS. The evidence may justify one pre-surgical visit for education and a home management program, or 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple physical therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple physical therapy office visits for recovery. Of course, these statements do not apply to cases of failed surgery and/or misdiagnosis (e.g., CRPS I instead of CTS). (Feuerstein, 1999) (O'Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006) Post surgery a home physical therapy program is superior to extended splinting. (Cook, 1995) Continued visits should be contingent on documentation of objective improvement, i.e., VAS improvement greater than four, and long-term resolution of symptoms. Therapy should include education in a home program, work discussion and suggestions for modifications, lifestyle changes, and setting realistic expectations. Passive modalities, such as heat, iontophoresis, phonophoresis, ultrasound and electrical stimulation, should be minimized in favor of active treatments.

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency, plus active self-directed home PT.

Medical treatment: 1–3 visits over 3–5 weeks

Post-surgical treatment (endoscopic): 3–8 visits over 3–5 weeks

Post-surgical treatment (open): 3–8 visits over 3–5 weeks.”

ODG, Forearm, Wrist, & Hand (Acute & Chronic), Procedure Summary – Forearm, Wrist, & Hand, Exercises:

“Recommend specific hand and wrist exercises for range of motion and

strengthening. Patients should be advised to do early passive range-of-motion exercises at home. Instruction in proper exercise technique is important, and a few visits to a good physical therapist can serve to educate the patient about an effective exercise program. Patients' at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Stretching exercises as recommended by AAOS have positive, limited evidence. (Various) (Handoll-Cochrane, 2002) (Handoll, 2006) There is limited evidence that nerve and tendon gliding exercises and wrist splinting result in superior static two-point discrimination compared to wrist splinting alone in the medium-term.”

ODG, Carpal Tunnel Syndrome (Acute & Chronic), Procedure Summary – Carpal Tunnel Syndrome, Exercises:

“Recommended. Recommend specific hand and wrist exercises for range of motion and strengthening. Patients should be advised to do early passive range-of-motion exercises at home. Instruction in proper exercise technique is important, and a few visits to a good physical therapist can serve to educate the patient about an effective exercise program. Patients' at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Stretching exercises as recommended by AAOS have positive, limited evidence. (Various references listed under "Activity & Exercise") (Seradge) (Verhagen-Cochrane, 2004) (Baysal, 2006) (Verhagen, 2006) There is limited evidence that nerve and tendon gliding exercises and wrist splinting result in superior static two-point discrimination compared to wrist splinting alone in the medium-term.”

ACOEM, Chapter 1, Prevention, Tertiary Prevention, pages 15 & 16:

“... reconditioning and avoidance of static position for long periods of time should help to prevent recurrences. Both aerobic conditioning and conditioning of specific muscle groups (e.g., forearm muscles or neck and shoulder musculature) should reduce the risk of future health problems.”

ACOEM, Chapter 5, Cornerstones of Disability Prevention and Management, C. Employee's/Patient's Role, page 83:

“To achieve functional recovery, patients must assume certain responsibilities. It is important that patients stay active and increase activity to minimize disuse, atrophy, aches, and musculoskeletal pain, and to raise endorphin levels. They must adhere to exercise.” It is the patient’s responsibility to stay active and increase activity to minimize disuse, atrophy, aches, and musculoskeletal pain, and they must adhere to exercise.

ACOEM, Chapter 6, Pain, Suffering, and the Restoration of Function, Summary, page 117:

“Maintaining function will minimize the stiffness, aches, and atrophy that result from being sedentary. Typically, when function improves, so does perceived pain.”

ACOEM, Chapter 11, Forearm, Wrist, and Hand Complaints, Table 11–4 Methods of Symptom Control for Forearm, Wrist, and Hand Complaints, page 264:

“Initial and follow-up visits for education, counseling, and evaluation of home exercise.”

ACOEM, Chapter 11, Forearm, Wrist, and Hand Complaints, Physical Methods, page 265:

“Instruction in home exercise. Except in cases of unstable fractures or acute dislocations, patients should be advised to do early range-of-motion exercises at-home. Instruction in proper exercise technique is important, and a physical therapist can serve to educate the patient about an effective exercise program.”

ACOEM, Chapter 11, Forearm, Wrist, and Hand Complaints, Physical Methods, page 265:

“Physical modalities, such as massage, diathermy, cutaneous laser treatment, “cold” laser treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback have no scientifically proven efficacy in treating acute hand, wrist, or forearm symptoms. Limited studies suggest there are satisfying short- to medium-term effects due to ultrasound treatment in patients with mild to moderate idiopathic CTS, but the effect is not curative. Patients’ at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist.”

ODG Treatment in Workers' Comp 2007, Philip L. Denniston, Editor-in-Chief,  
Work Loss Data Institute, Fifth Edition;  
Forearm, Wrist, & Hand (Acute & Chronic), Procedure Summary – Forearm, Wrist, &  
Hand, Physical/Occupational Therapy.  
Carpal Tunnel Syndrome (Acute & Chronic), Procedure Summary – Carpal Tunnel  
Syndrome, Physical Therapy.  
Forearm, Wrist, & Hand (Acute & Chronic), Procedure Summary – Forearm, Wrist, &  
Hand, Exercises.  
Carpal Tunnel Syndrome (Acute & Chronic), Procedure Summary – Carpal Tunnel  
Syndrome, Exercises.

Occupational Medicine Practice Guidelines, 2nd edition, American College of  
Occupational and Environmental Medicine, edited by Lee S. Glass, MD, published  
by OEM Press, Beverly Farms, MA, 2004; 15,16,83,117,262,265.