



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 04/07/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy three times a week for four weeks to include CPT codes 97001, 97002, 97110, 97140, 97124, and 97035

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

Board Certified in Family Practice
Board Certified in Preventive & Occupational Medicine

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.

Physical therapy three times a week for four weeks to include CPT codes 97001, 97002, 97110, 97140, 97124, and 97035 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRIs of the left foot and ankle interpreted by M.D. dated 02/06/06
MRIs of the left wrist and hand interpreted by Dr. dated 05/31/06
X-rays of the left wrist and hand interpreted by M.D. dated 05/31/06
A physical therapy request from M.D. dated 09/19/06
Evaluations with M.D. dated 01/25/07, 02/01/07, 03/12/07, 03/29/07, 04/30/07, 05/30/07, 07/13/07, 08/02/07, 08/10/07, 10/31/07, 12/05/07, 12/20/07, 02/07/08, and 03/13/08
An x-ray request from Dr. dated 01/25/07
DWC-73 forms from Dr. dated 01/25/07, 02/01/07, 03/12/07, 03/29/07, 04/30/07, 05/30/07, 08/02/07, 08/10/07, 09/21/07, 10/31/07, 12/05/07, 12/20/07, 02/07/08, and 03/13/08
Prescriptions from Dr. dated 03/12/07, 03/29/07, 09/21/07, 09/26/07, 10/31/07, 11/16/07, 11/20/07, 12/05/07, 12/06/07, 01/28/08, and 03/13/08
An evaluation with P.A.-C. for M.D. dated 01/24/08
On 01/28/08, Dr. wrote a referral form for a pain management program and physical therapy
On 01/30/08, Dr. provided a preauthorization request letter
On 02/01/08 and 03/12/08, provided letters of non-certification, according to the ODG
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the left foot interpreted by Dr. on 02/06/06 was unremarkable. A left ankle MRI interpreted by Dr. on 02/06/06 revealed a small ankle joint effusion. An MRI of the left wrist interpreted by Dr. on 05/31/06 revealed a triangular fibrocartilage complex (TFCC) tear and small ganglion cyst. An MRI of the left hand interpreted by Dr. on 05/31/06 was unremarkable. On 01/25/07, Dr. recommended Vicodin and Soma. On 03/12/07, Dr. recommended physical therapy. On 09/26/07, Dr. recommended a disability sticker. On 10/31/07, Dr. recommended a power chair, Naprosyn, Lidoderm patches, and Lexapro. On 01/24/08, Ms. recommended a pain management evaluation for possible pain management program, Mobic, Skelaxin, and Ultram. On 01/30/08, Dr. provided a preauthorization request for physical therapy three times a week for four weeks. On 02/01/08, wrote a letter of non-authorization for the physical therapy. On 03/12/08, wrote a letter of adverse determination for physical therapy.

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

The request for the physical therapy at three times a week for four weeks to include the CPT codes 97001, 97002, 97110, 97140, 97124, and 97035 would

not be considered reasonable or necessary at this point in time. First of all, the clinical record documented that she had had extensive physical therapy in the past, which did not help. That alone would be criteria enough to deny further physical therapy viewing the failure of the prior to provide benefit. I know of no rationale that would support repeating failed treatment. Additionally, the request would not be in line with the clinical literature and especially the ODG. According to the low back chapter, ODG physical therapy guidelines allow for fading of treatment frequency from up to three or more visits per week to one or less, plus an active self directed home program. For lumbar sprain or strains, 10 visits over an eight week period of time is considered appropriate. For sprains and strains of unspecified parts of the back, 10 visits over the period of time are considered acceptable. For lumbago, 10 visits over eight weeks. For sciatica, 10-12 visits over eight weeks. As such, the patient has already exceeded the recommendations of the guidelines without any apparent benefit. Interestingly, one of the treating doctors had mentioned referring her for a chronic pain management program. It would not seem to make sense to prescribe physical therapy and also an evaluation for a pain management program since physical therapy-type interventions are included as part of a chronic pain management program. Additionally, even if physical therapy were appropriate at this point, some of the modalities requested would not. For example, 97035 or ultrasound was requested. According to the ODG, therapeutic ultrasound is not recommended and there is no proven efficacy in the treatment of low back symptoms. The guidelines do note that therapeutic ultrasound is one of the most widely and frequently used electrophysical agents, but despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain remains questionable. There is little evidence that active therapeutic ultrasound is any more effective than placebo.

Therefore, the request for physical therapy three times a week for four weeks to include CPT codes 97001, 97002, 97110, 97140, 97124, and 97035 is not considered reasonable or necessary. The patient has already had extensive rehabilitation and failed to benefit. Additionally, the current request is not in line with the clinical literature or the ODG.

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)