

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: MAY 6, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3 x/week x 4 weeks - Cervical Spine -- to include 1) 97014/e-stim; 2) 97035/ultrasound; 3) 97110/therapeutic exercises; 4) 97140/manual therapy; 5) 97124/massage and 6) 97139/TENS application

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

MD, Board Certified Neurosurgeon

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female with a date of injury xx/xx/xx when she fell backwards. She sustained a wrist fracture and also struck her head on the ground. She complains of trapezius pain that sometimes radiates down the arm to the forearm. On exam, there is some giveway weakness of the left deltoid and biceps. The MRI 03/25/2008 of the cervical spine reveals moderate narrowing of the neuroforamen at C5-C6, left greater than right, and moderate narrowing of the left C3-C4 neuroforamen on the left.

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

The reviewer finds that Physical Therapy 3 x/week x 4 weeks - Cervical Spine -- to include 1) 97014/e-stim; 2) 97035/ultrasound; 3) 97110/therapeutic exercises; 4) 97140/manual therapy; 5) 97124/massage and 6) 97139/TENS application is not medically necessary.

According to ODG, Neck and Upper Back chapter, neck pain and cervical spondylosis warrant 9 visits of physical therapy over 8 weeks.

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](#). **Cervicalgia (neck pain); Cervical spondylosis** (ICD9 723.1; 721.0): 9 visits over 8 weeks

TENS: Not recommended as a primary treatment modality, but a one-month home-based TENS trial for neck pain may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration.

Therapeutic Exercises: Recommended. For mechanical disorders of the neck, therapeutic exercises have demonstrated clinically significant benefits in terms of pain, functional restoration, and patient global assessment scales. ([Philadelphia, 2001](#)); ([Colorado, 2001](#))

Ultrasound: Under study. There is little information available from trials to support the use of many physical medicine modalities for mechanical neck pain, often employed based on anecdotal or case reports alone. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. ([Gross-Cochrane, 2002](#)) ([Aker, 1999](#)) ([Philadelphia, 2001](#))

Massage: Recommended as an option.

2008 Official Disability Guidelines, 13th edition, “Neck and Upper Back” chapter

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)