



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

DATE OF REVIEW: September 22, 2008

IRO Case #:

Description of the services in dispute:

1. Items in dispute 12 sessions of physical therapy (#97110 – 4 unites, #97140, #98910, #97112, #97530, #98940, #G0283, #97035.

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

The chiropractor providing this review is a member of the American Chiropractic Association and the Texas Chiropractic College Alumni Association. The reviewer is an Approved Designated Doctor for Texas Workers Compensation and is MMI and Impairment Rating Approved. The reviewer has been conducting peer reviews since 2000 and has been in active practice since 1995. The reviewer has completed an orthopedic rotation at a state hospital and has completed over 100 hours of continuing medical education.

Review Outcome

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

Upheld

1. Items in dispute 12 sessions of physical therapy (#97110 – 4 unites, #97140, #98910, #97112, #97530, #98940, #G0283, #97035.

The request of 12 additional sessions of physical therapy to include #97110–4 units, #97140, #98910, #97112, #97530, #98940, #G0283, #97035 is not medically necessary based on current objective findings and parameters indicated in the ACOEM and ODG guide.

Information provided to the IRO for review

FROM THE STATE OF TEXAS:

Confirmation of receipt of a request for review by an IRO 8/29/08 – 4 pages

Request form for review by an IRO 8/19/08 – 3 pages

Letter 6/19/08 – 4 pages

Letter 7/17/08 – 3 pages

FROM SPINE & REHAB:

Request fro IRO for physical therapy 8/26/08 – 1 page

Non certification fax 7/16/08 – 1 page

Pre-authorization reconsideration 7/8/08 – 3 pages

Fax from Spine & Rehab pre-authorization request denial 6/16/08 – 1 page

Pre-authorization request letter 6/16/08 – 1 page

Pre-authorization request letter 7/9/08 – 1 page

Initial evaluation 3/22/07 – 3 pages

SOAP notes 4/25/07 – 6/5/07 – 13 pages

Subsequent evaluation 6/5/07 – 2 pages

SOAP notes 6/11/07 – 6/25/07 – 3 pages

Subsequent evaluation 7/10/07 – 2 pages

SOAP notes 7/10/07 – 8/8/07 – 5 pages

Subsequent evaluation 8/15/07 – 2 pages

SOAP notes 8/15/07 – 8/27/07 – 2 pages

Subsequent evaluation 9/4/07 – 2 pages

Subsequent evaluation 9/18/07 – 2 pages

SOAP notes 9/18/07 – 9/26/07 – 2 pages

Subsequent evaluation 10/23/07 – 2 pages

SOAP notes 10/23/07 – 1 page

Subsequent evaluation 11/27/07 – 3 pages

SOAP notes 11/27/07 – 1 page

Subsequent evaluation 1/4/08 – 3 pages

SOAP notes 1/4/08 – 3/11/08 – 4 pages

Subsequent evaluation 5/20/08 – 2 pages

SOAP notes 6/13/08 – 8/18/08 – 3 pages

Subsequent evaluation 1/4/08 – 3 pages

Final report 4/27/07 – 2 pages

Electrodiagnostic report 5/31/07 – 3 pages

Electrodiagnostic data sheet 5/31/07 – 1 page

History form 5/31/07 – 1 page

Examination report 5/31/07 – 1 page

Office visit notes 8/26/08 – 1 page

Letter from RN 9/9/08 – 1 page

Communication note 6/19/08 – 2 pages

Communication note 7/16/08 – 3 pages

Pre-authorization reconsideration 7/8/08 – 3 pages

Request for IRO for physical therapy 8/26/08 – 1 page

Confirmation fax of non certification 7/16/08 – 1 page

Pre-authorization reconsideration request 7/18/08 – 3 pages

Letter of reconsideration fax 7/9/08 – 1 page

Patient clinical history [summary]

The patient is a male who sustained a work related injury on xx/xx/xx. It has been documented that the patient has received 12 PT visits and it has been a year since the patient has received any type of therapy. The current visits in question were performed xx month post injury.

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

Per ODG Physical Therapy Guidelines: There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted; and (7) Generally there should be no more than 3 or 4 modalities/procedural units in total per visit, allowing the PT visit to focus on those treatments where there is evidence of functional improvement, and limiting the total length of each PT visit to 45-60 minutes unless additional circumstances exist requiring extended length of treatment. If additional circumstances are present, documentation must support medical necessity.

ACOEM indicates; guidance on the number of visits for these interventions with allied health professionals (e.g., physical therapists, occupational therapists, chiropractors) may be helpful for

treatment of LBP, including guiding a conditioning program, as well as other modalities as indicated elsewhere.

It should be expected that most patients with more severe acute and subacute LBP conditions receive 8 to 12 visits with allied health professionals over 6 to 8 weeks, as long as functional improvement and program progression are documented. Patients with mild symptoms may require either no therapy appointments or few appointments. Those with moderate problems may require 5 to 6 visits. (The number of recommended visits is the consensus of the Evidence-based Practice Spine Panel.)

Patients with chronic LBP who have not had prior treatment should follow similar guidance as those with acute LBP. Other chronic LBP patients may need more treatment. Factors influencing the number of visits needed include the content of prior treatment, patient response to prior treatment, their retention of information, and the exercises they were taught.

The patient sustained a work related injury on xx/xx/xx. It has been documented that the patient has received 12 PT visits and it has been a year since the patient has received any type of therapy. The current visits in question were performed xx month post injury. Current examination findings on 6/13/08 indicate orthopedic test findings of a positive Foraminal Compression and a positive Shoulder Depression. Spasms and tenderness were found in the right trapezius, right lower cervical and right cervical paraspinal muscles. MRI findings for the cervical spine indicate retrolisthesis of C5-C6 with a 4mm disc bulge and bilateral foraminal stenosis. At C6-7 there is a disc protrusion with flattening of the thecal sac. The findings are suggested to be related to the injury when the patient was "walking under a scaffold when one of his co-workers dropped a cordless drill from 19 feet high. The battery from the drill fell on the patient's head". On 3/22/07, the patient was examined and biceps reflex was found was graded at +1 with decreased to sensation to the C6 dermatome on the right. Motor testing indicated 4/45 strength to the right shoulder abduction and external rotation. Maximal foraminal compression and shoulder depression was positive bilaterally with increased pain to the cervical spine. Cervical ROM was mildly decreased. The patient was diagnosed as having a head injury (959.01) with associated headaches (784.0), cervical disc protrusion (722.2) and cervical sprain/strain (847.0). After 12 visits, the patient's symptoms and objective findings remained unchanged with continued pain rating at 6/10. ROM to cervical spine improved slightly. The patient continued to work 8 hours with restrictions and then on 9/18/07 decreased to 4 hours with restrictions. He continued to see Dr. for orthopedic consultation and continued to seek pain management. Dr. D.C. on 11/27/07 indicates continued 8 hours of work with work restrictions of no lifting objective heavier than 10 lbs, if this was not available the patient should be considered off work.

On 1/4/08, the patient's objective and subjective findings remained unchanged with the inclusion of EMG/NCV findings of C5 and C6 radiculopathy. The patient's condition was noted to worsen on 3/11/08. Past and current documentation does not support any significant changes or improvement in the patient's condition. The patient's condition worsened despite of orthopedic and pain management interventions. Functional gains were very limited and no change was made in the patient's work status. Therefore, the request of 12 additional sessions of physical therapy to include #97110-4 units, #97140, #98910, #97112, #97530, #98940, #GO283, #97035 is not medically necessary based on current objective findings and parameters indicated in the ACOEM and ODG guide.

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

Return To Work Guidelines (2007 *Official Disability Guidelines (ODG)* edition) Integrated with Treatment Guidelines (*ODG Treatment in Workers' Comp*, 5th edition)

ACOEM's *Occupational Medicine Practice Guidelines*, Second Edition

The American College of Occupational and Environmental Medicine (ACOEM)

Evaluation and Management of Common Health Problems and Functional Recovery in Workers