



Specialty Independent Review Organization

## Notice of Independent Review Decision

**DATE OF REVIEW:** 4/3/2009

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of physical therapy 3 x 6 consisting of 97002, 97001, G0283pnr, 97035, 97110, 97014, 97116, and 97140.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation as well as Pain Management. This provider performs this type of service in his office and has been practicing for greater than 10 years.

### **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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of physical therapy 3 x 6 consisting of 97002, 97001, G0283pnr, 97035, 97110, 97014, 97116, and 97140.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

Therapy Services  
Workers' Comp Services

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Therapy Services authorization request – 2/26/09, SOAP notes – 2/24/09, PT letter – 3/2/09.

Records reviewed from Therapy Services: PT letter – 3/11/09, Evaluation – 12/10/08; Therapy Services flowsheet – 12/10/08 – 3/3/09, Physical therapy referral – 12/9/08, SOAP notes – 12/10/08-3/3/09, Discharge/Progress summary – 12/17/08, 1/22/09, & 2/24/09.

A copy of the ODG was not provided by the carrier, URA, or WCN for the review.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient has undergone meniscectomy of the knee on xx/xx/xx. He has undergone 24 visits of PT. From note on 3/11/09, the patient has been diagnosed with RSD. Peer reviewer, MD, documents that lumbar sympathetic blocks were requested by Dr. and denied. He has edema, limits in ROM, and chronic pain. The peer reviewers have denied the treatment solely based upon the ODG guidelines for meniscectomy. It is the reviewer's opinion that the RSD treatment guidelines should be considered as well.

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

The ODG recommends a hierarchy of options as indicated below. The goal is to improve function. Multiple pathophysiological mechanisms are responsible including neuropathic (sympathetic and independently-maintained pain), and immunologic (regional inflammation and altered human leukocyte antigens). Both peripheral sensitization and central sensitization have been proposed. There are no evidence-based treatment guidelines but several groups have begun to organize treatment algorithms. Recommendations:

1. Rehabilitation: (a) Early stages: Build a therapeutic alliance. Analgesia, encouragement and education are key. Physical modalities include desensitization, isometric exercises, resisted range of motion, and stress loading. If not applied appropriately, PT can actually be detrimental. (b) Next steps: Increase flexibility with introduction of gentle active ROM and stretching (to treat accompanying myofascial pain syndrome). Other modalities may include muscle relaxants, trigger point injections and electrical stimulation (based on anecdotal evidence). Edema control may also be required (elevation, retrograde sympathetic blocks, diuretics and adrenoceptor blockers when sympathetically maintained pain-SMP is present). (c) Continued steps: Continue active ROM; stress loading; scrubbing techniques; isotonic strengthening; general aerobic conditioning; and postural normalization. (d) Final steps: Normalization of use; assessment of ergonomics, posture and modifications at home and work. In some cases increased requirements of analgesic medications, psychotherapy, invasive anesthetic techniques and SCS may be required.

Regarding manual therapy, the ODG recommends this treatment specifically in the lower back and neck sections. They are obviously widely used for

musculoskeletal pain. However, the ODG does not recommend them in the knee section.

The patient has undergone 24 visits of PT. For a diagnosis of RSD the ODG supports 26 visits. The request for 18 more PT visits are not supported by the ODG. Therefore, the requested services are not medically necessary per the records provided.

**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)**