

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/07/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Physical Therapy x 12 Sessions, Neck

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

MD, Board Certified in Physical Medicine and Rehabilitation

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines, Physical Therapy
Adverse Determination Letters, 10/18/09, 11/3/09
Clinic, 11/16/09, 10/26/09
Physical Therapy Evaluation, 10/9/09

PATIENT CLINICAL HISTORY SUMMARY

This is a woman who was injured on xx/xx/xx. The records indicate she has had 14 sessions of therapy and two prior ESIs.

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

The only physician records provided for this review were a letter of appeal and a therapy note. There was no report of injury or prior treatments. One reviewer noted the 14 prior sessions of therapy and ESIs. The only diagnosis provided is neck pain and the reason for the additional therapy is that she has not improved. The ODG permits 9-10 sessions of therapy for cervicgia and sprains over 8 weeks. The requested 12 additional sessions exceed the permitted limit as per the ODG. The provider in this case has not given a justification of why she could not be in a self directed program, and why there is the need for 12 sessions in addition to the 14 she already received. The reviewer finds that medical necessity does not exist at this time for Physical Therapy x 12 Sessions, Neck.

Physical therapy (PT)

Recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider, to avoid debilitation and further restriction of motion. (Rosenfeld, 2000) (Bigos, 1999) For mechanical disorders for the neck, therapeutic exercises have demonstrated clinically significant benefits in terms of pain, functional restoration, and patient global assessment scales. (Philadelphia, 2001) (Colorado, 2001) (Kjellman, 1999) (Seferiadis, 2004) Physical therapy seems to be more effective than general practitioner care on cervical range of motion at short-term follow-up. (Scholten-Peeters, 2006) In a recent high quality study, mobilization appears to be one of the most effective non-invasive interventions for the treatment of both pain and cervical range of motion in the acutely injured WAD patient. (Conlinl, 2005) A recent high quality study found little difference among conservative whiplash therapies, with some advantage to an active mobilization program with physical therapy twice weekly for 3 weeks. (Kongsted, 2007) See also specific physical therapy modalities, as well as Exercise.

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, including assessment after a "six-visit clinical trial"

Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0)

9 visits over 8 weeks

Sprains and strains of neck (ICD9 847.0)

10 visits over 8 weeks

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE

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)