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Notice of Independent Review Decision

DATE OF REVIEW: 2/6/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy to the Back and Neck (therapeutic exercises, heat/cold and electrical stimulation)

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

Certified by the American Board of Physical Medicine & Rehabilitation

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective		97140	Upheld
		Prospective		97014, 97012	Upheld
		Prospective	724.1	97110, 97010	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Progress notes dated 12/31/08

Treatment memo dated 1/6/09, 11/24/08, 10/9/08

Limits of Stability Test Results

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Initial Evaluation/Plan of Care and Daily notes dated 12/31/08, 12/30/08, 12/29/08, 12/18/08, 12/16/08, 12/15/08, 12/12/08, 12/10/08, 12/8/08, 12/3/08

Official Disability Guidelines (ODG) provided: Physical medicine treatment, Physical therapy (PT)

PATIENT CLINICAL HISTORY:

This xx-year-old claimant sustained an injury on xx/xx/xx, after falling into a container when reaching to put parts into the container. Lumbar spine injury and cervical spine injury were noted. Treatment has included physical therapy and medications. Reportedly, progress was being made but there was still a pain level of 8/10.

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

It is noted that the date of injury is xx/xx/xx. The care was started at this provider sometime in late 2008. According to the 1/6/09 progress note, a functional capacity evaluation was completed and reviewed, it was noted there is some confusion about the inclusion of the lumbar region of the spine (low back) or if it is the thoracic region of the spine, and the pain complaints at this time remained “8/10.” The assessment of 1/6/09 noted that the cervical strain had resolved, the meniscal lesion was resolved and the thoracic strain was persistent. According to the documentation provided, it was noted that ten sessions of physical therapy were completed in December 2008, addressing the thoracic and cervical spine.

As per the neck and upper back section of the Division mandated Official Disability Guidelines, updated December 2008, up to nine sessions of physical therapy are endorsed.

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. ([ConlinI, 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

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[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

In the Reviewer's opinion, there is no clinical data presented that repeating physical therapy is clinically indicated. The Reviewer noted the date of injury, the ongoing complaints, and the claimant's pain level of 8/10, indicating that there is no efficacy or utility of this protocol.

**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)

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