

US Decisions, Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 2, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3 times per week times 4 weeks; (12 sessions) cervical spine.

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

M.D., Board Certified Orthopedic Surgeon

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for physical therapy 3 times per week times 4 weeks; (12 sessions) cervical spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/15/08, 01/08/09

ODG Guidelines and Treatment Guidelines

PT Daily Progress Notes, 11/15/08

PT re-evaluation, 11/20/08

Office notes, Dr. 12/05/08, /12/19/08
Prescription for therapy, 12/05/08
Pre-auth request form, undated

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a right hand dominant female who was injured in a motor vehicle accident on xx/xx/xx. She reportedly started physical therapy on 10/28/08. A therapy re-evaluation on 11/20/08 noted that she had been off work since xx/xx/xx and was treating for her right shoulder and neck. The therapist reported that a shoulder MRI on 11/04/08 noted no acute trauma and tendinosis. The therapist noted that a cervical MRI showed possible increased T2 hyperintensity at the C5-6 articular facet. She complained of right upper trapezius and shoulder pain with limited motion and functional deficits and occasional numbness and tingling in digits 2-4 on the right. She reported compliance with her home exercise program. Active cervical range of motion was: flexion and extension 90 percent of normal, right lateral flexion 75 percent of normal, left lateral flexion 90 percent of normal and bilateral rotation 80 percent of normal. She had pain and tenderness of the upper trapezius with moderate spasm and tenderness, pain in the right shoulder, acromioclavicular joint, greater tuberosity and bicipital tendon in the groove and posterior occiput. Upper extremity strength was normal. Continuation of therapy was recommended.

Dr. saw the claimant on 12/05/08 for the chief complaint of cervical pain. He stated that the CT of the neck and spine showed no evidence of fracture and no specific mention of the C5-6 finding noted on the previous MRI. There was a prominent cervical lymph node that the radiologist felt was reactive. Good cervical motion, still with tenderness was noted. Continued therapy was recommended and the studies were to be re-reviewed by the radiologist. On 12/15/08 the request for an additional 12 sessions of therapy was denied. Dr. re-evaluated the claimant on 12/19/08 and noted that they had gotten clarification of the CT. It was felt that the lymph node in her neck had gotten a little larger. She now had pain going down into the right arm and desired to return to therapy. Good cervical motion with some tenderness over the right side were noted. EMG/NCV studies of the right upper extremity and therapy were recommended. Therapy was again denied and is currently under dispute.

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

Twelve sessions of formal therapy are documented. The ODG guidelines recommend ten visits over eight weeks. An additional 12 visits of physical therapy are not medically necessary in this case. The request exceeds the number of visits recommended in the guidelines and the medical records do not document why the recommendations should not be followed in this patient's case. The reviewer finds that medical necessity does not exist for physical therapy 3 times per week times 4 weeks; (12 sessions) cervical spine.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, (i.e. Neck - Physical Therapy)

Displacement of cervical intervertebral disc:
Medical treatment: 10 visits over 8 weeks

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)