



Notice of Independent Review Decision

DATE OF REVIEW: 3/3/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for 12 sessions of physical therapy (97110, 97140, G0283).

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

Texas licensed Chiropractor

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 previously denied request for 12 sessions of physical therapy (97110, 97140, G0283) is modified to a clinical trial of 6 physical therapy visits with CPT codes of 97110 – therapeutic exercises (4 units) and 97140 – manual therapy (myofascial release), one unit. The previous denial for CPT code G0283 – interferential (IF) current therapy/electrical stimulation is upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice to CompPartners, Inc. of Case Assignment dated 2/26/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 2/25/09.
- Request Form dated 2/20/09.
- Request for Review for Physical Therapy Letter dated 2/20/09.
- Notice of Reconsideration dated 1/13/09.
- Reconsideration for Physical Therapy Letter dated 1/7/09.
- Pre-Authorization Request dated 1/7/09, 12/23/08.
- Notice of Denial of Pre-Authorization dated 12/30/08.
- Subsequent Evaluation Report dated 12/16/08.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury:

Mechanism of Injury: Lifting

Diagnosis: Neck sprain, lumbar intervertebral disc displacement without myelopathy, myalgia, muscular wasting and disuse atrophy, thoracic or lumbosacral neuritis or radiculitis.

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

This is a female who sustained a work related injury on xx/xx/xx, when she was lifting some parts while working as a. The provided diagnoses included 847.0-neck sprain, 722.10-lumbar IVD displacement without myelopathy, 729.1-myalgia, 728.2-muscular wasting and disuse atrophy not elsewhere classified and thoracic or lumbosacral neuritis or radiculitis, unspecified. The claimant had presented to a chiropractic provider , DC. The provided preauthorization request was dated 1/7/09 for 12 sessions of physical therapy to include CPT codes of 97110-therapeutic exercises-4 units, 97140- manual therapy (myofascial release therapy)-one unit and G0283-interferential current-1 unit. There was a similar request dated for 12/23/08. The documentation on 12/16/09 from Dr. indicated evidence of a flare-up of neck and back pain rated 6/10, brought on from the cold weather. The home exercises were making her worse. The orthopedic tests included straight leg raising (SLR) to 40 degrees on the left and 45 degrees on the right, cervical foraminal compression and cervical distraction tests and shoulder depression tests bilaterally. Valsalva's test was positive for low back pain. There were trigger points. There was 4/5 weakness in right biceps flexion. There was sensory decreased bilaterally at the C6 dermatome and the right L5-S1 dermatome. Reflexes were +2. Range of motion of the cervical spine were indicated as flexion of 40/60 degrees, extension of 40/75 degrees, left lateral flexion of 35/45 degrees, right lateral flexion of 30/45 degrees, left rotation of 55/80 degrees and

right rotation 60/80 degrees. The lumbar spine range of motion was indicated as flexion 32/60 degrees, extension at 8/25 degrees, left lateral flexion at 4/25 degrees and right lateral flexion at 15/25 degrees. There was also reference to findings on MRI of the lumbar spine which revealed a L4-5 3mm subligamentous disc herniation. There was also noted a grade spondylolisthesis at L5-S1, with a 1 cm disc herniation with indentation on the thecal sac and the left S1 nerve root. The MRI of the cervical spine performed on 10/18/06 revealed a 3mm left paracentral disc herniation at C3-4 and at C5-6 level a 4 mm subligamentous disc herniation with mild canal stenosis and narrowing of the bilateral neural foramen. At C6-7 there was a 5.0 mm left parasagittal disc herniation noted flattening the thecal sac with bilateral foraminal encroachment. The electromyogram (EMG) revealed evidence of C6, C6 and C7 nerve root irritation. The office note indicated that the claimant had not been approved for physical therapy (PT) at this clinic since the March 2006 initial request. The current request is to determine the medical necessity for twelve physical therapy treatments with CPT codes of 97140-manual therapy (myofascial release) one unit, 97110-therapeutic exercises 4 units and G0283-electrical stimulation/interferential current. The medical necessity for a modification to this request was established for a clinical trial of 6 physical therapy visits with CPT code of 97110-therapeutic exercises (4 units each date) and 97140-manual therapy (myofascial release) only. The modality of interferential therapy was not found medically necessary. The reference to the ODG, Treatment Index, 7th Edition (web) regarding Chronic neck and back complaints and recommendations for manual therapy, interferential current therapy and therapeutic exercises. Reference directed to <http://www.odg-twc.com/odgtwc/pain.htm#Manualtherapymanipulation> indicates that manual therapy is *“Recommended for chronic pain if caused by musculoskeletal conditions and manipulation is specifically recommended as an option in the Low Back Chapter and the Neck Chapter.* (For more information and references, see those chapters.) Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the Low back: *Recommended as an option. Therapeutic care – Trial of 6 visits over 2 weeks,*” to determine efficacy of care for this claimant and that for *“Recurrences/flare-ups – Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months.”* Therefore, six visits are found appropriate at this time for a trial of care for her chronic condition with exacerbation documented. For the 97110-therapeutic exercises, reference is redirected to <http://www.odg-twc.com/odgtwc/pain.htm#Exercise> , which indicates that they are *“Recommended”* and that *“A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime.”* Therefore, the 6 visits should be sufficient to address the flare-up and re-educate the claimant on her home program. For the modality of interferential current with CPT code of G0283, the reference is re-directed to <http://www.odg-twc.com/odgtwc/pain.htm#Interferentialcurrentstimulation> which indicates that

“The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and knee pain. The findings from these trials were either negative or insufficient for recommendation due to poor study design and/or methodologic issues. In addition, although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions.”

Therefore, this modality is not medically necessary. The reference found at <http://www.odg-twc.com/preface.htm#PhysicalTherapyGuideline> states that *“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.”* Therefore, this modification to six visits is found appropriate at this time. Finally, this determination would meet the Texas Labor Code 408.021 and specific commission rule TWCC 134.1001 (C) (1) (A) states: *The employee is specifically entitled to healthcare that: (1) Cures or relieves the effects naturally resulting from the compensable injury (2) Promotes recovery OR; (3) Enhances the ability of the injured worker to return to or retain employment.*

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES. ODG, Treatment index, 7th edition web based version regarding chronic neck and back complaints and recommendations for manual therapy, interferential current therapy and therapeutic exercises.

<http://www.odg-twc.com/odgtwc/pain.htm#Manualtherapymanipulation>

<http://www.odg-twc.com/odgtwc/pain.htm#Interferentialcurrentstimulation>

<http://www.odg-twc.com/odgtwc/pain.htm#Exercise>

<http://www.odg-twc.com/odgtwc/pain.htm#Physicalmedicinetreatment>

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.

TEXAS TACADA GUIDELINES.

TMF SCREENING CRITERIA MANUAL.

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).

X OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).

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