



Medical Review Institute of America, Inc.
America's External Review Network

DATE OF REVIEW: November 17, 2009

IRO Case #:

Description of the services in dispute:

Items in dispute are 12 sessions of physical rehabilitation. (CPT codes #97110, #97140, and #97112)

A description of the qualifications for each physician or other health care provider who reviewed the decision

This reviewer is a diplomate of the American Board of Family Practice. This reviewer is a member of the American Association of Family Physicians. This reviewer has been in active practice since 1999.

Review Outcome

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

Upheld

The 12 additional sessions of physical rehabilitation are not medically necessary, as they exceed the recommended number of visits outlined in the guidelines. The clinical information obtained does not establish the medical necessity, clinical utility, or anticipated potential benefits of the requested 12 physical therapy sessions.

Information provided to the IRO for review

Records from the State:

Confirmation of Request for Review, 10/28/09, 4pgs

Request for Review 10/27/09, 3pgs

Utilization Review 10/12/09, 2pgs

Utilization Review 10/22/09, 2pgs

Records from Provider:

Letter from IRO Coordinator 10/30/09, 1pg

Pain and Recovery Clinic, MD, Request for Reconsideration 10/16/09, 2pgs
Supplemental Report of Injury (illegible date and signature), 2pgs
Request for Pre-Authorization, 10/8/09, 1pg
Request for Pre-Authorization, 9/23/09, 1pg
Daily Progress Note, DC, 9/22/09, 1pg
Supplemental Report of Injury, (illegible signature), 9/22/09, 1pg
Initial Consultation, MD, 9/18/09, 2pgs
Radiology Report, DC, 9/18/09, 1pg
Physical Therapy Evaluation, MD, 9/18/09, 3pgs
Texas Worker's Compensation Work Status Report, (illegible signature), 9/18/09, 1pg
Notice of Disputed Issue(s) and Refusal to Pay Benefits, 7/13/09, 1pg
Exit Interview (effective date) 10/1/09, 1pg
Employer's First Report of Injury or Illness, Personnel Coordinator, 7/9/09, 1pg
Independent Review Organization Summary, 10/30/09, 2pgs

Patient clinical history [summary]

Per the doctor's note from 9/18/09, the patient is a female patient, who presented with complaints of discomfort of cervical area, bilateral shoulder, and thoracic area. She has complaints of headache and pain radiating to her bilateral shoulders. On her clinical exam, it is noted that she has a normal neurological exam with normal reflexes, gait, and cranial nerves 2-12 intact. She has mild tenderness of the cervical spine and paracervical muscles. She has normal strength of all extremities. She has tenderness of bilateral shoulders with decreased range of motion. Her diagnoses are cervical sprain, and shoulder and upper arm sprain.

The reported date of injury was xx/xx/xx. The mechanism of injury was that the patient had a fainting episode related to a past medical history of a seizure disorder; and fell backwards and hit her head.

Her current medications are Meloxicam, A-PAP/Propoxyphene, Dilantin, Potassium, and Ultram.

Diagnostic imaging indicated the following:

1. Right and left shoulder X-ray 9/18/09

Findings - There is no evidence of recent fracture or gross osteopathy in either shoulder. The bone density is normal. There is normal bony alignment. The joint spaces are well maintained. There is normal articulation of the AC (anterior cruciate) and GH (glenohumeral) joints. There is no indication of other osseous or soft tissue pathology.

2. Cervical X-ray 9/18/09

Findings - The bone density appears normal. There are seven normal cervical vertebrae, vertebrae

bodies and posterior elements are intact. The disk spaces are well maintained. There is loss of cervical lordosis. There is no scoliotic curvature. There are no significant osteoarthritic changes. There are no indications of osseous or soft tissue pathology.

The number of previous physical therapy visits is not clearly specified.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The date of injury is xx/xx/xx. During the injury, the patient had a fainting episode related to a past medical history of a seizure disorder. She fell down, sustaining a laceration to her scalp, which was repaired in the emergency department.

The clinical notes mentioning the diagnosis of cervical/neck pain are from 9/18/09, which was xxxx months after the injury. The clinical notes from the date of injury until 9/18/09 are not specified in the records provided. The clinical notes of the emergency department visit on xx/xx/xx are not provided in the records submitted. The notes of follow-up visits between xx/xx/xx and 9/18/09 are not provided in the records submitted. The date of onset of the neck pain, the response to other conservative measures including NSAIDS, and a home physical therapy program between xx/xx/xx and 9/18/09 is not specified in the records provided. An X-ray report dated 9/18/09 is normal for bilateral shoulders and cervical spine.

As per ODG Guidelines, when treatment duration or the number of visits exceeds the guidelines, exceptional factors should be noted.

The reported injury date was approximately xxxx months ago. Cervical sprain and shoulder sprain are expected to resolve within the time span of 4 months. Per ODG Guidelines, PT, if indicated, is most effective in the acute phase of the illness during short term follow up.

With this, it is deemed that the clinical information obtained does not establish the medical necessity, clinical utility, and anticipated potential benefits of the requested 12 physical therapy sessions.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Official Disability Guidelines Treatment in Workers' Comp., online Edition
Chapter: Neck and Upper Back

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. (Conlin, 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

ODG Preface

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.