

## Notice of Independent Review Decision

### **IRO REVIEWER REPORT**

DATE OF REVIEW: 05/11/10

IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

(12 sessions) Initial Physical Therapy – Right Shoulder and Cervical (97140, G0283, 97140 and 97010 x 4 units

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

The TMF physician reviewer is a board licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

### 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.

It is determined that the (12 sessions) Initial Physical Therapy – Right Shoulder and Cervical (97140, G0283, 97140 and 97010 x 4 units are not medically necessary to treat this patient's condition.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 04/26/10
- Adverse Determination Letter from xxxxx – 02/01/10, 03/05/10, 03/22/10
- Pre-authorization request – 01/27/10
- Initial evaluation from xxxxx – 01/22/10
- Reconsideration for Physical Therapy from Dr. – 03/05/10
- IRO request for physical therapy from Dr.– 04/19/10

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained an injury on xx/xx/xxxx when he was driving a vehicle backwards and hit a parked trailer. This resulted in pain to the abdomen as well as at his cervical region with tingling and numbness down his right arm. He has undergone one session of physical therapy and the treating doctor states that the patient continues to have increased levels of pain and restriction that is progressively limiting his ability to complete his activities of daily living. The treating doctor has recommended twelve sessions of physical therapy.

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

Based on the medical record documentation provided for review, this patient was seen for initial evaluation on 01/22/10 and there were subjective symptoms and objective finding present at this examination. While it appears that physical therapy was necessary for the treatment on this on-the-job injury, the ODG guidelines are very clear and specific as to the fact that only 10 physical therapy visits are within the guidelines for this patient diagnosis (see guidelines below).

#### 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, 200) See also specific 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 condition 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 the neck (ICD9 847.0): 10 visits over 8 weeks

Displacement of cervical intervertebral disc (ICD9 722.0): 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)