COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 5/11/10

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for physical therapy, 2 times per week for 2 weeks, to consist of the following modalities (CPT Codes) 97535, 97110, 97530, 97140.

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)

X 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 physical therapy, 2 times per week for 2 weeks, to consist of the following modalities (CPT Codes) 97535, 97110,

97530, 97140 is modified to include only one (1) physical therapy visit with only one (1) unit each CPT code including 97535-self care home management instruction, 97110-therapeutic exercise, 97530-therapeutic activities and 97140-manual therapy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Letter from Claims Adjuster dated 5/4/10.
- UR Reconsideration Uphold/Corrected Letter dated 5/4/10.
- UR Denial by PA (TX) dated 3/22/10.
- Office Consultation dated 3/19/10.
- Patient Face Sheet dated 3/16/10.
- Re-Evaluation dated 3/10/10.
- Patient Information/Authorization Request dated 3/1/10.

PATIENT CLINICAL HISTORY (SUMMARY):

Gender: xxxxxx

Mechanism of Injury: xxxxxx

Diagnosis: 723.1- cervicalgia.
847.0- cervical sprain,
847.1- thoracic sprain and 840-shoulder sprain

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

This xxxx" tall, xxxx pound right hand dominant xxxxx who sustained a work related injury. The mechanism of injury was described as a motor vehicle accident where xxxx was the driver of a vehicle which was rear ended. The provided diagnoses included 723.1-cervicalgia, 847.0-cervical sprain, 847.1-thoracic sprain and 840-shoulder sprain. A previous review indicated that the injured worker was taken to an emergency room and received X-rays at Concentra. No X-ray findings were submitted within this review packet. It was reported that she had received at least ten (10) physical therapy sessions to date. The injured worker was treating with provider DO, and chiropractic provider DC. The re-evaluation report from Dr. dated 3/10/10, indicated 5/10 pain in the neck, upper back and right shoulder. It was described as occasional and a burning sensation. It was worse on the right side. Activities of daily living (ADL) continued to be aggravating factors. Deep tendon reflexes (DTR) were 1+ bilaterally in the upper and lower extremities. The ranges of motion (ROM) of the right shoulder were noted as "improved" but still deficit. Cervical ROM were flexion 40 degrees, extension 30 degrees, left lateral flexion 20 degrees, right lateral flexion 30 degrees, left rotation 60 degrees and right rotation 50 degrees. Motor testing of the bilateral upper extremities was 5/5 bilaterally, except for right side was 4+/5 in the deltoids and shoulder abductors. Grip strength was noted as left 50-45-45 and right 50-40-45. Positive orthopedic tests included shoulder depressor on the right side and bilateral Jackson's test. Dr. reported that xxxxx was

scheduled for a cervical spine epidurals steroid injection (ESI) and he recommends continued physical therapy at 2 times per week for 2 weeks to maximize the benefits of the injection therapy, as well as decrease pain and improve function. The injured worker subsequently underwent a cervical ESI on 3/19/10 with MD, who does not report any complications following this procedure. The current request is to determine the medical necessity for physical therapy at two times per week for two weeks with CPT codes including 97535-self care home management instruction (for four units each date); 97110-therapeutic exercise (for four units each date); 97530-therapeutic activities (for four units each date); and 97140-manual therapy (for four units each date). The medical necessity for this request was established for a modification to include one physical therapy visit with only one unit of each CPT code of 97535-self care home management instruction, 97110-therapeutic exercise, 97530-therapeutic activities and 97140-manual therapy. This would allow for re-education and review of self care management and transition to an independent home exercise program (HEP), as well as address any remaining deficits in function with supervised therapeutic exercise and activities and mobilization/manual therapy. The Guidelines do allow for 1-2 visits post injection therapy. This modification to one additional visit should be adequate to allow her to continue her HEP post injection therapy given she has received the recommended number of physical therapy visits of 10 visits for the cervical spine and right shoulder since February of 2010 alone. There were no complicating factors to consider otherwise to appreciate medical necessity for more than one additional visit. The reference to support modification determination is found in the Return To Work Guidelines (2010 Official Disability Guidelines, 15th edition) Integrated with Treatment Guidelines (ODG Treatment in Workers' Comp, 8th edition) web based version regarding physical therapy for cervical and shoulder regions. Overall, for cervical sprain strain the guidelines recommend “10 visits over 8 weeks”. xxx has received this amount, but does have some remaining deficits. xxxx also had extenuating circumstance of a 3/19/10 cervical ESI procedure. The guidelines indicate “Post injection treatment 1-2 visits over one week”. This reference also indicates that physical therapy is “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. For mechanical disorders for the neck, therapeutic exercises have demonstrated clinically significant benefits in terms of pain, functional restoration, and patient global assessment scales. Physical therapy seems to be more effective than general practitioner care on cervical range of motion at short-term follow-up. 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”. Additionally, for manual therapy reference is directed to manipulation. This reference indicates that the best evidence “suggests that therapies involving manual therapy and exercise are more effective than alternative strategies for patients with neck pain”. For the shoulder regarding physical therapy, the ODG recommends up to “10 visits over 8 weeks”. xxxx again, has already received this amount. The reference also indicates that “Upper quarter joint mobilizations in combination with therapeutic exercise were more effective than exercise alone”. This would support the therapeutic activities, home exercise self care management to improve activities

of daily living (ADL), therapeutic exercises and mobilization/manual therapy for both the cervical and shoulder regions. The reference specifically to CPT code of 97535 is found in the CPT code list of the ODG. This reference indicates this is for “Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes”. The overall request indicated includes four units each date for each CPT code. The medical necessity for only one unit each date for each code is appreciated since only one area indicated to be the cervical spine is receiving the injection and there are minimal deficits with the shoulder. This should be sufficient given the provided information and lack of complicating factors to consider at this time.

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.
Return To Work Guidelines (2010 Official Disability Guidelines, 15th edition) Integrated with Treatment Guidelines (ODG Treatment in Workers' Comp, 8th edition) web based version regarding physical therapy for cervical and shoulder regions. http://www.odg-twc.com/odgtwc/neck.htm#Physicaltherapy (activities, exercises, mobilization) http://www.odg-twc.com/odgtwc/neck.htm#Manipulation (manual therapy/mobilization) http://www.odg-twc.com/cpt_9.htm (self care management) http://www.odg-twc.com/odgtwc/shoulder.htm#Physicaltherapy

□ 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).

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