

Notice of Independent Review Decision

DATE OF REVIEW: MARCH 17, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Prospective preauthorization of physical therapy services, twelve treatment sessions, four *CPT* codes 97110, 97112, 97140, and 97530

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

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.

Following review of the documents, it is recommended that the original denial of services be upheld with denial of preauthorization.

Utilizing the *ODG* and in consideration of the requestor's diagnoses, including postconcussion syndrome, cervical pain, and vertigo, the *ODG* criteria for the services being requested were reviewed.

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In terms of the diagnosis of postconcussion syndrome, the *ODG* notes that this diagnosis is not recommended and that for clinical treatment purposes the use of postconcussion syndrome, postconcussive syndrome, or postconcussion disorder as a diagnosis is not recommended. The unique, individual pattern of symptoms should be documented and be the focus of treatment.

In relationship to the physical therapy component, including physical medicine services, the *ODG* also notes that as this patient most closely is noted to have a neck sprain/strain and/or head concussion, treatment of up to ten visits over the course of eight weeks may be considered as reasonable and necessary. At this point in time, some year post injury, the effects of a self-limited sprain/strain/contusion would be expected to have cleared or would not be impacted by the recommended treatment

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 13 page fax 03/02/XX IRO request, 135 page fax 03/04/XX URA response to disputed services including administrative and medical records.

- Denial of request for physical therapy by M.D., 01/20/XX.
- Denial for reconsideration 02/03/XX by M.D.
- Employer's First Report of Injury indicating she was working and was injured XX/XX/XX.
- Worker's Statement of Injury.
- Clinic for dates of service 03/04/XX, 03/05/XX, 03/08/XX, 03/11/XX, 04/02/XX, 04/21/XX, 04/28/XX, 05/24/XX, 05/28/XX, 06/04/XX, 06/15/XX, 07/07/XX, 07/21/XX, and 12/20/XX; also, 01/04/XX.
- Medical records from M.D., neurology, dates of service 04/23/XX, 05/21/XX, 06/04/XX, 06/18/XX, 07/07/XX, and 07/21/XX.
- Brain MRI 03/30/XX.
- Clinic, for dates of service 01/14/XX, 01/15/XX, 01/17/XX, 01/19/XX, 01/24/XX, 01/26/XX, 02/01/XX, 02/02/XX, 02/09/XX, and 02/14/XX.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the available medical information documents that were provided for this IRO review, this claimant was working. She was working, apparently, a storage type of area, and while working around some shelving or while she was attempting to get something off a shelf (two different mechanisms of injury are described within the documents), a shelf fell, striking the right side of her head. She reported no loss of consciousness, temporary disorientation, and lethargy and was referred initially to clinic.

She was treated at clinic from 03/04/XX through 01/04/XX. She had therapy, regular medical evaluation, referral for a brain MRI 03/30/XX with no abnormality

noted, and neurology consultation with M.D., and then, beginning 01/14/XX, transfer of medical care to D.C., where he instituted some manual chiropractic care and has requested a program of physical medicine.

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

Following review of the documents, it is recommended that the original denial of services be upheld with denial of preauthorization.

Utilizing the *ODG* and in consideration of the requestor's diagnoses, including postconcussion syndrome, cervical pain, and vertigo, the *ODG* criteria for the services being requested were reviewed.

In terms of the diagnosis of postconcussion syndrome, the *ODG* notes that this diagnosis is not recommended and that for clinical treatment purposes the use of postconcussion syndrome, postconcussive syndrome, or postconcussion disorder as a diagnosis is not recommended. The unique, individual pattern of symptoms should be documented and be the focus of treatment.

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REFERENCE FOR DENIAL:

Post-concussion syndrome	Not recommended. For clinical treatment purposes the use of post-concussion syndrome, post-concussive syndrome (PCS) or post-concussion disorder (PCD) as a diagnosis is not recommended. The unique individual pattern of symptoms should be documented and be the focus of treatment. (Cifu, 2009)
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. (Conlinl, 2005) A recent high

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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

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)