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Notice of Independent Review Decision

**Date notice sent to all parties:** 08/28/14

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Board Certified in Orthopedic Surgery  
Diplomate of the American Board of Orthopedic Surgeons  
Fellow of the American Academy of Orthopedic Surgeons  
Fellow of the American Association of Orthopedic Surgeons

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

Twelve visits of physical therapy

**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 medical necessity exists for each of the health care services in dispute.

Twelve visits of physical therapy - Upheld

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient presented to the emergency room on xx/xx/xx. He had back pain status post crush injury, as well as left arm and neck pain. He denied LOC and was ambulatory at the scene. Neurological examination was normal. Chest x-rays revealed left apical capping compatible with subpleural hemorrhage and possible subjacent pulmonary contusion. A small left hemothorax was seen. X-rays of the left shoulder revealed a markedly displaced/distracted left clavicular mid shaft fracture. The AC joint appeared intact and there was a non-displaced partial left second rib fracture. A CT scan of the abdomen revealed a large distal gastric antrum possible, small probable duodenal fatty lesions that could be lipomas. The cervical CT scan revealed displaced C6, C7, and upper thoracic spinous process fractures, but no acute vertebral body fracture or subluxation. The thoracic CT scan revealed displaced lower cervical and T1-T4 spinous fractures without evidence of acute vertebral body fracture or subluxation. The lumbar CT scan was within normal limits. The facial CT scan revealed bilateral facial injury with a slightly distracted right sided mandibular fracture. No intraorbital injury was noted. performed ORIF of the left mid shaft clavicular fracture and exploration and ligation of the vertebra on 11/25/13. The postoperative diagnoses were mid shaft left clavicular fracture, scapular dissociation, and avulsion of the vertebral vein from subclavian. performed chest tube placement on 11/28/13 due to a left pleural effusion/hemothorax. examined the patient on 12/13/13. He had neck pain, thoracic pain, left arm pain, and left arm swelling. Back range of motion showed no significant loss of motion and it was pain free and without spasm. Neck range of motion was essentially within normal limits and was pain free and without spasm. Upper extremity strength was 5/5 bilaterally and deep tendon reflexes were symmetric bilaterally. Sensation was intact and range of motion of the all the joints of the upper extremity were normal. He had tenderness of the lower cervical and upper thoracic spine and swelling of the left pectoral muscle, and mild swelling of the hand. The impressions were cervical spine/thoracic spine pain, history of spinous process fractures, history of mandible fracture, and history of clavicle fracture. A hard collar was recommended, as well as an MRI. His pain medications were refilled. examined the patient on 12/19/13. His staples were removed and he had a resolving hematoma inferior to the clavicle incision. He was distally neurologically intact. X-rays revealed a comminuted clavicle fracture with satisfactory alignment. Percocet was refilled and a short prescription of OxyContin was provided. Physical therapy was recommended two to three times a week for four weeks. He was evaluated in therapy on 01/13/14. Left shoulder flexion was 58 degrees, external rotation was 30 degrees and internal rotation was 60 degrees. Cervical flexion was 24 degrees and rotation was 28 degrees on the left and 36 degrees on the right. The patient attended therapy on 01/13/14, 01/15/14, 01/17/14, 01/22/14, 01/24/14, and 01/31/14. It was noted he was a no show for 01/20/14. On 01/22/14, he stated he was not feeling well, so that's why he did not come in on 01/20/14. On 01/27/14, he called and said his driver did not show up, so he could not come to his therapy appointment. On 01/29/14, he was a no show, as he had an MRI scheduled that day. He received electrical stimulation, range of motion exercises, and therapeutic exercises. A cervical MRI

dated 02/03/14 revealed no significant abnormality and no fractures or disc protrusions. A thoracic MRI also performed on 02/03/14 revealed some chronic appearing degenerative changes of the T9-T10 and to a lesser degree at T10-T11 discs with some minor posterior convexity at T9-T10, but without spinal cord distortion or high grade neural foraminal compromise at any level. An addendum that day noted with additional history and review of the studies, there was some abnormal edema with cortical discontinuity at C5, C6, C6, T1, and likely T2 consistent with recent fractures. Abnormal edema was also seen at T3, T4, and T5 consistent with non-displaced fractures and/or bone bruising. The patient continued in therapy on 02/03/14, 02/05/14, 02/10/14, 02/12/14, 02/14/14, and 02/17/14. He cancelled his therapy on 02/07/14 and he was a no show on 02/19/14. On 02/04/14, reevaluated the patient. He was not wearing the collar due to claustrophobia and his neck pain was worsened. Cervical range of motion was limited by pain. The recent MRIs were reviewed. He would be kept off of work and therapy was prescribed. Motrin and Tylenol ES were prescribed. A cervical collar was again recommended. In a therapy note dated 02/26/14, it was noted he had been placed on hold per the case manager until an MRI of the shoulder was done. A left shoulder MRI dated 03/04/14 revealed mild infraspinatus tendinosis versus strain without tear and labral blunting without definite tear. There was susceptibility artifact along the left clavicle likely secondary to hardware, which limited assessment. There was a partially imaged edema like signal along the fat planes adjacent to the axillary neurovascular bundles extending proximally and beyond the field of view. The findings were noted to be of indeterminate age. examined the patient on 03/13/14. He noted had declined further follow-up, so he was transferred ongoing management. He agreed that Oxycontin was not good long term. Cymbalta, Nucynta, and a Lidoderm patch were prescribed, as well as physical therapy. On 03/18/14, the patient cancelled his therapy, as he had another appointment that day. He attended therapy on 03/21/14 and 03/26/14, but missed 03/28/14 and 03/31/14 due to illness. noted on 03/25/14 that she agreed that a portion of the patient's pain appeared to be non-organic. She released the patient to care. She noted the left shoulder MRI revealed chronic, age related changes and no acute tear. On 03/25/14, also examined the patient. He noted no surgical intervention was necessary and no further treatment, from his standpoint, was recommended. He placed him at MMI. He was given a 15% impairment for the cervical spine. He advised the patient to resume physical activity. The patient continued in therapy on 04/07/14, 04/09/14, 04/11/14, 04/14/14, and 04/16/14. He was a no show on 04/18/14. reexamined the patient on 04/14/14. His main complaint was cervicospinal pain with left shoulder pain. The Cymbalta had seemed to help somewhat. His mental affect was better. There was breakaway weakness noted in the bilateral upper extremities, which appeared to be the only abnormal finding. noted the patient continued to have symptoms of non-organic pain with strength testing and had failed Ultram and Nucynta. He had a preference for Oxycontin, which did not feel was the best option. Continued therapy and Embeda were prescribed, as well as continued Cymbalta. He would continue on light duty. A urine drug screen was collected that day. On 04/21/14, the patient called therapy and said he had missed his last appointment due to car trouble. He was to return

on 04/23/14. On 05/12/14, noted therapy had been denied and he had had 16 – 18 visits. He had left shoulder pain and occasional numbness and tingling of the left upper extremity. He had breakaway weakness of the left upper extremity and significant pain to palpation of the left clavicular region. He had painful and reduced cervical range of motion. The impressions were cervicospinal pain with history of spinous process fractures, healed, left shoulder pain with history of clavicle fracture, and left upper extremity numbness, tingling, and paresthesias with some non-organic breakaway weakness on examination. felt therapy was warranted. Neurontin and Cymbalta were prescribed. did not feel the patient was at MMI. On 06/17/14, cervical extension was 20 degrees, and left rotation was 20 degrees. Flexion was full and left side bending was 20-30 degrees. Side bending to the right was 5/5. felt the patient had predominately neuropathic pain and a possible slight brachial plexus contusion, but no atrophy. He felt therapy longer than the usual recommendations was warranted. Neurontin and Cymbalta were continued. On 07/18/14, provided an adverse determination for the requested 12 sessions of therapy. On 07/30/14, provided an adverse determination for the requested 12 sessions of therapy.

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

The patient is a male who sustained a crush injury on xx/xx/xx, which resulted in a left clavicle fracture, right mandible fracture, left hemothorax, and C6 to T4 spinous process fractures based on the documentation provided. The patient subsequently underwent open reduction and internal fixation of the left clavicle and right mandible fractures. He has completed at least 19 formal physical therapy sessions, but also no-showed for some of the sessions and cancelled some of the sessions, as well. released him from care regarding his cervical spine on 03/24/14 and noted he had reached MMI. released him from care regarding his left clavicle fracture on 03/25/14 and also noted that the claimant showed signs of non-organic pain. The request for therapy was originally reviewed an orthopedic surgeon, on 07/18/14 and denied. a physiatrist, upheld the denial on re-consideration on 07/30/14. Both physician reviewers cited the ODG criteria as the basis of their decision. Both reviewing physicians attempted a peer-to-peer with the requesting physician without success. in addition, noted that the patient missed multiple physical therapy appointments either no-showing or cancelling.

The evidence based ODG typically recommends eight visits of physical therapy over ten weeks for a clavicle fracture. The clavicle fracture has subsequently healed, as documented in the records, and his operative surgeon has released him from care, as noted above. Non-organic pain has been identified by several physicians based on the records reviewed. The request is not supported by the objective physical findings in the materials reviewed. In addition, there have been significant gaps in his therapy and at least three no-shows and some cancellations, suggesting possible non-compliance with the treatment regimen. There is no indication based on the documentation reviewed that the claimant is performing a home exercise program, which should have been instructed to him

in the therapy he had already received. The necessary objective findings to support going beyond the recommended therapy timeframe of the ODG is not provided. Additional sessions of physical therapy do not appear medically necessary, reasonable, related, or supported by the ODG. Both felt that there was no medical indication for further active treatment and the claimant was released to care. Therefore, the request for 12 visits of physical therapy is not medically necessary, reasonable, related, or supported by the evidence based ODG at this time and the previous adverse determinations should be upheld 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 & 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)**