

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Date notice sent to all parties]:

03/15/2016

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: PT 3X per week
for 4 weeks**

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

Board Certified PM&R

REVIEW OUTCOME:

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

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is XX/XX/XX. The patient reports that he was running when he fell and landed on a table and hit his stretch. He said his left upper extremity was outstretched to break his fall. MRI of the cervical spine dated XX/XX/XX revealed posterior disc herniation measuring approximately 3 mm at C5-6 indenting the thecal sac with minimal non-compressive stenosis. Thoracic MRI dated XX/XX/XX revealed mild anterior wedge deformity of the T11 and T12 vertebral bodies. The patient underwent cervical epidural steroid injection on XX/XX/XX, XX/XX/XX and XX/XX/XX. EMG/NCV revealed electro-diagnostic evidence of a left C5 radiculopathy; mild right median entrapment neuropathy at the wrist (carpal tunnel syndrome). Initial evaluation dated XX/XX/XX indicates that the patient complains of pain on his neck with tingling sensation on the left shoulder. He also reports pain on the left wrist. He reports physical therapy treatment months ago. Current medication is Tramadol. On physical examination cervical

range of motion is flexion 60, extension 30, bilateral lateral flexion 40 degrees. Left shoulder range of motion is flexion 170, extension 60, abduction 150, ER and IR 85 degrees. Left wrist range of motion is flexion 60, extension 60, radial deviation 30 and ulnar deviation 40 degrees. Office visit note dated XX/XX/XX indicates that the patient is not taking any pain medications. On physical examination cervical range of motion is mildly decreased. There is tenderness over the bicipital groove on the left shoulder. Lumbar range of motion is moderately decreased. Impression is contusion to chest wall. The patient was recommended for a course of physical therapy to decrease pain and increase functionality.

Initial request for physical therapy 3 x per week for 4 weeks was non-certified on XX/XX/XX noting that records provided indicate the claimant has completed an undetermined amount of PT. Objective evidence of improvement towards clear, objectively measurable, functional treatment goals must be achieved/submitted before additional treatment can be considered appropriate. There is no evidence of improvement as no previous PT treatment notes are provided. He should be familiar with a home program and should be encouraged to continue self-treatment. There are no extenuating circumstances noted to exceed current treatment guidelines or that the claimant cannot participate in a home exercise program. The denial was upheld on appeal dated XX/XX/XX noting that the patient has complaints of neck pain with radiating pain to the left wrist. There is an indication the patient has previously undergone a course of physical therapy. Additional therapy is indicated for patients with ongoing deficits identified by clinical exam and there is an indication of an objective functional improvement through the initial course of treatment. No information was provided confirming the patient's objective improvements through the previously rendered treatment. Given the lack of objective data confirming the patient improvements through the previously completed therapy, the request is not indicated.

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

Based on the clinical information provided, the request for physical therapy 3 x per week for 4 weeks is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The submitted records indicate that the patient has undergone prior physical therapy; however, there is no specific information provided regarding physical therapy including dates of service, number of sessions completed and patient response. The Official Disability Guidelines would support additional physical therapy with evidence of objective functional improvement. The patient should be well-versed in and encouraged to perform an independent, self-directed home exercise program for any remaining deficits. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

IRO REVIEWER REPORT TEMPLATE -WC

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**
- X 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**
- 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)**

Physical medicine treatment

Recommended as indicated below. Physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy, Chiropractic, and MD/DO). Passive therapies (those treatment modalities that do not require energy expenditure on the part of the patient) are not indicated for addressing chronic pain in most instances; refer to the specific modality within ODG (e.g., massage, ultrasound). Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Refer to the specific intervention within these guidelines (e.g., exercise). This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) As far as medical necessity considerations for exercise equipment, see the Knee Chapter, Durable medical equipment (DME), & the Low Back Chapter, Exercise. Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)

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.

Myalgia and myositis, unspecified:

9-10 visits over 8 weeks

Neuralgia, neuritis, and radiculitis, unspecified:

8-10 visits over 4 weeks

Reflex sympathetic dystrophy (CRPS):

26 visits over 16 weeks

Arthritis:

9 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (see also body-part chapters): 18 visits over 12 weeks

Patients should be formally assessed after a "six-visit clinical trial" to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy.