

AccuReview

An Independent Review Organization
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May 28, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy x 18 visits (97116, 97112, 97110, 97530, 97140, 97150, 97010, 97161, and 97164)

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

This physician is Board certified in Rehabilitation and Physical Medicine Physician with over 18 years of experience.

REVIEW OUTCOME:

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

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]:

XXXX: Physical Therapy Request dictated by XXXX. PT Area Neck, evaluate and treat, ROM, strengthening, stabilization, teach home exercises. DX: Acute cervical radiculopathy 723.4, M54.12.

XXXX: XX dictated by XXXX. DX: M54.12 radiculopathy, cervical region. Treatment DX: M54.2 cervicalgia, R29.3 abnormal posture, M52.81 muscle weakness (generalized), M25.6 stiffness of unspecified joint. CC: XXXX with neck pain, bilaterally. Claimant was injured on XXXX when XXXX and felt pain in right shoulder. Thought maybe XXXX pulled a muscle at that time and worked the rest of XXXX shift. The next day woke up and could hardly move arm. Went to the ER and took x-rays of shoulder and did not see anything and was referred to ortho for follow-up. XXXX completed PT to right shoulder for 6 weeks without improvement and then PT was suggested for neck. Claimant had MRI, steroid injection, EMG study. Pain is located right side neck pain from behind ear to shoulder blade and down back side of arm. Starts out dull ache and gets worse as the day goes on. Numbness down the 4th and 5th fingers. Keeping arm supported makes it feel better. Symptoms staying the same over time. Except yesterday felt a sharp in the right side of the neck suddenly (did try doing some housework yesterday). Currently not working without a return to work date due to XXXX. XXXX stated that the pain at best is a 1 and 6/10 at worst. XXXX recently has also been diagnosed with conditions related to heart disease (AFIB and hypertension). Assessment: Impairments ROM, muscle strength, pain, posture, joint mobility, impaired muscle endurance and impaired flexibility. Functional Limitations in functional capacity and performance, limitations in home management, performance in leisure activities, performance in self-care ADL and performance in work activities. Disability work barriers and see functional limitations. Prevention need for fitness, need for prevention, need for risk reduction and need for wellness. Clinical Impression: Patient presents to clinic with referring dx of acute cervical radiculopathy with c/o right sided neck and arm pain with intermittent numbness. Pt reported initial injury occurred at work on XXXX and XXXX previously received one course of PT for the right shoulder last year, as that was original diagnosis. Now claimant being referred to PT for cervical spine. Pt demonstrates poor posture with forward head, rounded shoulders and thoracic kyphosis along with R UE weakness thoracic spine hypomobility, loss of cervical ROM, decreased flexibility in upper traps and weakness in

cervical DNF muscles all contributing to XXXX c/o pain and numbness and inability to perform work duties. XXXX would benefit from therapy to address identified impairments to reduce pain and return to full work duties. Treatment POC: precaution, manual therapy 15 min, therapeutic exercise 15 min, neuromuscular reeducation 15 min, functional activities 15 min, group therapy, PT hot pack, PT cold pack, elect stim unattended press other, gait training 15 min, PT re-eval est plan care 20 min, and PT eval low complex 20 min.

XXXX: Workers' Compensation Authorization Request Form dictated by XXXX. Request: PT 3x week x 6 weeks for 18 visits 97161, 97164.

XXXX: UR performed by XXXX. Reason for denial: There is no documentation noting objective outcome from prior therapy nor current range of motion values on P. Further, the requested number of sessions in addition to the already completed therapy exceeds recommendations set forth by guidelines regarding total duration of treatment. Additionally, a rationale indicating the need for the number of modalities was not provided.

XXXX: UR performed by XXXX. Reason for denial: The request was denied on XXXX, the reviewer noted there was no documentation noting objective outcome from prior therapy nor the current range of motion values on physical examination. Further, the requested number of sessions in addition to the already completed therapy exceeds recommendations set forth by guidelines regarding total duration of treatment. Additionally, a rationale indicating the need for the number of modalities was not provided. This request is for an appeal, and The ODG supports 9 visits for cervicalgia. The claimant has already had 18 visits. The current documentation does not support 18 additional visits. Therefore, the request for physical therapy 3 times a week for 6 weeks is not medically necessary and non-certified.

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

Denial of 18 Physical Therapy sessions is UPHELD/AGREED UPON since the request exceeds ODG recommended number of sessions for submitted diagnosis of cervical radiculitis/neuritis, and clinically there is lack of physical exam findings suggestive of this diagnosis including no neural tension testing such as Spurling's maneuver or Tinel testing, no objective sensory/motor/deep tendon reflex deficits, no results of the aforementioned EMG, no confirmation of compliance and progress with previous Physical Therapy to the original diagnosis to the shoulder, and no confirmation of compliance with home exercise program with that previous Physical Therapy. There is also no clinical rationale provided for the request of passive modalities of heat and ice, particularly now in the chronic stage 7 months post injury. Therefore, after reviewing the medical records and documentation provided, the request for Physical Therapy x 18 visits (97116, 97112, 97110, 97530, 97140, 97150, 97010, 97161, 97164) is not medically necessary and remains denied.

Per ODG:

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)**