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Review Outcome

Description of the service or services in dispute:

Six sessions of the physical therapy for the cervical spine (3X week for 2 weeks)
98940 Joint Mobilization
97140 Myofascial Release
97035 Ultrasound therapy
97110 Therapeutic Exercises (2 units)

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Licensed Chiropractor

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

☐ Overturned (Disagree)

☑ Upheld (Agree)

☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX with a diagnosis of a strain of muscle and tendon at neck, level, initial encounter (S16.1XXA) and radiculopathy of the cervical region (M54.12). XX was injured on XXXX while XX.

According to the office visit dated XXXX by XX, the patient complained of neck pain with a score of 7/10 and left arm tingling with a rate of 8/10. The pain was sharp and intermittent. The aggravating factors included staying still. The relieving factor included movement and prescribed medications. The associated symptoms included left arm tingling and left weak elbow flexion. On examination, Jackson's compression test was positive bilaterally. The cervical range of motion showed normal flexion of 45 degrees with pain, an extension of 50 degrees with pain, left flexion of 35 degrees with pain, right flexion of 35 degrees with pain, left rotation of 65 degrees with pain, and right rotation of 70 degrees without pain. The sensation was normal except at C5 and C6, which were decreased. The deep tendon reflexes showed 2 at C5 bilaterally, 1 at the left C6 and C7, and 2 at the right C6 and decreased at the right C7. The motor strength was 5/5 in all muscle groups except for C7, which was decreased. On XXXX, XX continued with complaints of neck pain and numbness in the left hand. This visit is handwritten and partially illegible. On XXXX, XX complained of left neck pain, numbness to left elbow/arm and arm weakness. Neck examination showed tenderness. This visit is handwritten and partially illegible.

A cervical CT scan report dated XXXX revealed no findings worrisome for the presence of a fracture or dislocation. There was an apparent focal disc protrusion at C6-C7 on the left side in the left paramedian and subarticular region. An MRI of the cervical spine dated XXXX showed an acute left-sided C6-C7 disc protrusion into the left foramen. That might explain the left C7 symptoms. There was spinal canal stenosis in the midline was 9.4 mm. There were an osteophyte and underlying acute disc extrusion complex at C5-C6 with spinal canal stenosis of 9.8 mm. An osteophyte and disc complex were seen at C4-C5 and although there was a narrowing of the ventral subarachnoid space, there was no central canal stenosis. The treatment to date included medications and physical therapy.

Per a utilization review decision letter dated XXXX, the requested service was not authorized. The reason for the determination was that the Official Disability Guidelines could not support the medical necessity for the specific request. As documented in the summary, previous treatment had included access to treatment in the form of supervised rehabilitation services. The noted reference would

support an expectation for an ability to perform a proper non-supervised rehabilitation regimen when an individual has received access to the amount of supervised rehabilitation services previously provided. The specific request would exceed what would be supported per criteria for the described medical situation. Consequently, at the time, medical necessity for the specific request as submitted was not established.

Per a utilization review decision letter dated XXXX, the requested service of six sessions of physical therapy was not authorized. According to the submitted medical documentation and the peer-to-peer conversation, the patient had XX sessions of physical therapy. XX had reached the maximum number of physical therapy sessions allowed by Official Disability Guidelines (ODG). Therefore, additional care was not supported. Furthermore, there was a lack of evidence demonstrating that the patient could not participate in a self-direct physical therapy at home to address any residual issues. Hence, the service was denied.

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 Six sessions of the physical therapy for the cervical spine (3X week for 2 weeks) 98940 Joint Mobilization, 97140 Myofascial Release, 97035 Ultrasound therapy, 97110 Therapeutic Exercises (2 units) is not recommended as medically necessary, and the two previous denials are upheld. The submitted records indicate that the patient has completed XX physical therapy visits to date. Current evidence based guidelines support up to 9 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers
- ☐ Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back
- ☐ Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
  ODG Chiropractic Guidelines –
  ● *Regional Neck Pain:*
  9 visits over 8 weeks
- ☐ 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)