



PROFESSIONAL ASSOCIATES

DATE OF REVIEW: 04/18/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Two units of physical therapy (97110, 97112) three times a week for two weeks and an EMG of the lower extremities

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

Licensed by the Texas State Board of Chiropractic Examiners

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the thoracic spine interpreted by M.D. dated 01/31/06
A peer review from M.D. dated 03/18/06
An evaluation with D.C. dated 02/06/07
A letter of non-certification from D.C. dated 02/09/07
A letter of denial from dated 02/12/07
A medical record review from M.D. dated 03/04/07

A letter of denial from D.C. dated 03/14/07
A position statement from R.N. dated 04/02/07

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the thoracic spine interpreted by Dr. was unremarkable. On 03/18/06, Dr. felt the patient required no further treatment or medications and could return to work without restrictions. On 02/06/07, Dr. requested a lumbar MRI and an EMG study, along with active rehabilitation. On 02/09/07, Dr. wrote a letter stating the lumbar MRI, EMG study, and rehabilitation were not medically necessary. On 02/12/07, Ms. also wrote a letter of non-certification for those recommendations. On 03/04/07, Dr. recommended no further treatment or medication and he requested a Functional Capacity Evaluation (FCE). On 03/14/07, Dr. wrote letters of non-certification for physical therapy and an EMG study. On 04/02/07, Ms. indicated that the carrier upheld its denial for an EMG study.

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

Based on the ODG Guidelines for EMG testing, such a study would be necessary after approximately one month of conservative therapy but would not be necessary if radiculopathy is clinically obvious, as is in this situation. It does not appear that the patient's condition is progressive in nature. The only benefit to an EMG study in this situation would be for assistance in determining impairment rating using the AMA Guides. The patient has already undergone her Designated Doctor Evaluation, has been placed at MMI, and assigned a whole body percentage of permanent impairment. Therefore, such a study would serve no purpose in this case. With regard to the physical therapy three times a week for two weeks, again the patient has been placed at MMI in July 2006. She has undergone a significant amount of physical therapy far beyond the normal ODG Guidelines. Prior to this request, there has been no documentation indicating any significant change in her condition. She would be served just as well from performing a home-based exercise program as one in a clinic setting. Therefore, the two units (97110, 97112) of physical therapy three times a week for two weeks as well as the EMG study of the lower extremities would not have been reasonable or necessary.

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 AND KNOWLEDGE BASE
- 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)

AMA Guidelines to Permanent Impairment 4th Edition