CompPartners

DATE OF REVIEW: 4/24/07 **AMENDED DATE: 5/17/07**

MDR TRACKING #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy, twelve sessions, for the cervical and thoracic spine.

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

Texas licensed D.C. and is also currently listed on the TDI/DWC ADL list.

REVIEW OUTCOME

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

X Upheld (Agree)

□ Overturned (Disagree)

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

[Check only one of the boxes above.]

The previously denied request for physical therapy two times a week for four weeks, for the cervical and thoracic spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. **Letters dated 4/11/07, 4/4/07, 2 pages.**
2. **Fax Cover Sheets/Comments dated 4/2/07, 3/22/07, 2 pages.**
3. **Notice of Assignment of Independent Review Organization dated 4/2/07.**
4. **Notice to CompPartners, Inc. of Case Assignment dated 4/2/07.**

5. **IRO Request Form dated 3/02/07, 6 pages.**
6. **Request for a Review by an independent Review Organization dated 3/20/07, 3 pages.**
7. **Designated Doctor/Appointment Date/Time Notification Letter dated 3/26/07, 1 page.**
8. **Exercises/Treatment Notes dated 4/4/07, 3/28/07, 3/20/07, 3/14/07, 3/7/07, 3/2/07, 2/23/07, 2/21/07, 2/14/07, 2/12/07, 2/7/07, 1/24/07, 1/19/07, 1/15/07, 1/12/07, 1/9/07, 1/4/07, 12/29/06, 12/27/06, 12/13/06, 12/11/06, 12/8/06, 12/6/06, 12/4/06, 11/29/06, 11/27/06, 11/22/06, 11/20/06, 11/17/06, 11/15/06, 11/13/06, 11/10/06, 11/8/06, 11/6/06, 11/3/06, 11/1/06, 10/30/06, 10/27/06, 10/25/06, 10/23/06, 1/20/06, 10/18/06, 10/17/06, 43 pages.**
9. **Cover Letter/Computerized Spinal Range of Motion Exams dated 4/4/07, 2/14/07, 10/4/07, 11/10/06, 44 pages.**
10. **Comprehensive Examination Reports dated 3/28/06, 2/14/07, 1/4/07, 11/17/06, 10/17/06, 20 pages.**
11. **SOAP Notes dated 4/4/07, 3/28/07, 3/20/07, 3/14/07, 3/7/07, 3/2/07, 2/23/07, 2/21/07, 2/20/07, 2/14/07, 2/12/07, 2/7/07, 1/24/07, 1/19/07, 1/15/07, 1/12/07, 1/9/07, 1/4/07, 12/29/06, 12/27/06, 12/13/06, 12/11/06, 12/8/06, 12/6/06, 12/4/06, 11/29/06, 11/27/06, 11/22/06, 11/20/06, 11/17/06, 11/15/06, 11/13/06, 11/10/06, 11/8/06, 11/7/06, 11/6/06, 11/3/06, 11/1/06, 10/30/06, 10/27/06 10/25/06, 10/23/06, 10/20/06, 10/18/06, 10/17/06, 24 pages.**
12. **Office Visit Reports dated 3/15/07, 2/15/06, 2 pages.**
13. **Prescriptions dated 4/4/07, 3/28/07, 3/15/07, 2/15/07, 2/14/07, 2/12/07, 1/12/07, 12/29/06, 12/8/06, 10/17/06, 10/25/06, 12 pages.**
14. **Cervicothoracic Ultrasound dated 11/7/06, 1 page.**
15. **Cervical/Thoracic Spine X-Ray dated 10/24/06, 1 page.**
16. **Cervical Spine MRI dated 9/11/06, 2 pages.**
17. **Referral Form dated 10/4/06, 1 page.**
18. **Prescriptions for Course of Treatment Authorization dated 2/26/07, 1/4/07, 11/17/06, 10/20/06, 4 pages.**
19. **Procedure Reports 2/16/07, 12/15/06, 4 pages.**
20. **Letters of Medical Necessity and Pertinent Doctor Notes dated 2/26/07, 1/4/07, 12/29/06, 11/17/06, 10/20/06, 5 pages.**
21. **Certification of Medical Necessity dated 10/31/06, 1 page.**
22. **Follow-Up Visit Note dated 9/27/06, 2 pages.**
23. **New Patient Visit Report dated 12/12/06, 3 pages.**
24. **Texas Workers' Compensation Work Status Report dated 12/12/06, 1 page.**
25. **Review Determination Notification Letters dated 3/5/07, 2/21/07, 1/11/07, 11/28/06, 10/25/06, 10 pages.**
26. **Medical Examination Report/Letter dated 11/2/06, 7 pages.**
27. **Insurance Information Sheet (unspecified date), 1 page.**

<u>INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:</u>

Patient's Age:

Gender: Female
Date of Injury:
Mechanism of Injury: While attending a work function, the patient was driving a go-kart that was struck by another vehicle, resulting in an injury to the patient's neck, mid-back and right foot.

Diagnoses: Cervical and thoracic disc syndrome, nerve root compression.

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

The patient initially presented to the office of Dr. complaining of neck, mid-back and right foot pain. An evaluation was performed and an MRI was ordered. The MRI of the cervical spine, dated 9/11/2006, revealed a disc herniation at C5-6, with mild to moderate spinal stenosis and a mild cord deformity. At C6-7, there was mild spinal stenosis as a result of a posterior disc protrusion. On 6/2/2006, the patient underwent a neurologic evaluation and electromyogram/nerve conduction velocity (EMG/NCV) testing of the upper extremities. This test proved to be negative for radiculopathy or neuropathy.

On 6/26/2006, Dr. evaluated the patient and recommended epidural steroid injections. On 7/7/2006 and 7/26/2006, the patient underwent cervical and epidural steroid injections. On 10/17/2006, the patient changed treating providers to Dr. D.C. An evaluation was performed and a recommendation for therapy, at three times per week for four weeks, was submitted. Through 4/4/2007, the patient received 46 physical therapy treatments with Dr..

On 2/14/2007, the patient underwent a re-examination. This resulted in a request for treatment at two times per week for four weeks. This was initially denied by peer review on 2/21/2007. The request for this treatment was denied on appeal on 3/5/2007. The purpose of this independent review is to determine the medical necessity for the retrospective requested eight treatments. The medical necessity for the requested eight treatments was not established. Through 2/14/2007, the patient received a total of 37 physical therapy treatments. In addition, the patient received several cervical epidural steroid injections.

A comparison of the serial examinations dated 11/10/2006, 1/4/2007 and 3/14/2007, revealed additional improvement through 1/4/2007. From 1/4/2007 through 2/14/2007, there was not a significant amount of improvement in ranges of motion findings. The whole person impairment steadily increased from 14% in November to 16% in January and 19% in February. This clearly suggests that the patient was not improving and had reached maximum therapeutic benefit with respect to the treatment rendered. It would be unlikely to note significant improvement in the patient's condition following additional physical therapy. When compared to the 4/4/2007 examination, this was borne out. From 2/14/2007 through 4/4/2007, cervical extension and bilateral rotation decreased. Lateral flexion revealed a 4 degree improvement and flexion improved and remained in excess of

normal. The whole person impairment rating for 4/4/2007 was noted to be 16%, suggesting, again, that the patient had plateaued.

A review of the SOAP notes beginning 12/13/2006 through 4/4/2007, revealed pain levels that remained at three out of 10 on the visual analogue scale. Again, this suggests that the patient's condition had reached maximum therapeutic benefit. The provider submitted a letter dated 4/4/2007, which indicated the patient "showed impairment values." This statement is true in that there were impairment values. However, there was no change in the impairment values over the three serial examinations. The provider further stated that "in closing, all these exams and testing indicate that Ms. is not at maximum medical improvement (MMI) at this time and she needs more active therapy rehabilitation of her cervicothoracic areas." The submitted documentation does not support this statement that the patient is not at MMI at this time.

While the patient may continue to have subjective complaints, there is no evidence that continuation of the current treatment program will provide any significant additional benefit. As the time of this request, the patient had received 37 physical therapy treatments. The requested twelve treatments clearly exceed the recommendations set out by the *Official Disability Guidelines (ODG) Treatment Index, 5th Edition, 2006/2007.* Therefore, consistent with these guidelines, the medical necessity for the requested twelve additional physical therapy treatments was not established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[Check any of the following that were used in the course of this review.]

X ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE, Chapters 6 and 8.

□ 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHRIOPRACTIC 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.