



DATE OF REVIEW: 05/15/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Hot tub.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.O. Board Certified in Physical Medicine and Rehabilitation, Pain Management

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. Report dated 03/12/07 from URA reviewer
2. Note dated 04/06/07 from URA reviewer
3. Letter of medical necessity from treating doctor (TD) dated 03/27/07
4. Report dated 03/21/07
5. Note from TD dated 12/27/06
6. Peer Review dated 02/05/07
7. Psychological evaluation report from dated 10/10/06 with Axis I diagnosis of dysthymic disorder, mild; Axis II diagnosis was personality disorder
8. Note dated 10/12/06
9. Note dated 09/27/06 from TD, as well as a 06/26/06 report from him
10. Peer Review report dated 05/09/06
11. Peer Review report dated 08/02/05
12. EMG report dated 04/30/04 showing chronic left C7 and left C6 radiculopathy
13. Report dated 04/03/04 from TD
14. MRI scan report dated 04/29/04, stating “There has been an anterior cervical fusion with instrumentation at C5/C6 as described. There is mild bulging of the annulus at C3/C4. Otherwise, negative MRI study of the cervical spine is described.”

15. Note dated 04/15/04 TD
16. Report dated 11/15/02 from TD, as well as 06/28/02 report from him
17. Physical therapy note dated 01/18/02
18. Note from 02/19/02 from TD
19. Physical therapy report of 12/17/01
20. Report dated 01/09/02 from TD
21. Report from TD dated 12/07/01 discussing an 11/29/01 EMG study showing left C6/C7 denervation
22. On 12/05/01 notes indicated that she did have some mild C7 root irritability on electrodiagnostic studies.
23. CT scan of the cervical spine dated 11/29/01 showing left C6/C7 disc herniation with postoperative changes and solid anterior cervical fusion at C5/C6 with anterior plate and screw instrumentation and asymmetric spondylosis to the right at C4/C5 with mild encroachment on the right neural exit foramen, anterior spondylitic bony ridging at C3/C4 and C4/C5
24. Report from dated xx/xx/xx
25. Independent Medical Evaluation of 01/21/00
26. Report from TD dated 05/12/00
27. X-rays of the cervical spine and right shoulder were taken on 10/22/99 showing “stable appearance of the previously described anterior cervical fusion with accompanying mild foraminal encroachment”
28. Report dated 03/23/99 from TD
29. Report dated 02/23/99 from TD
30. Radiology report dated 07/14/98, an MRI scan of the cervical spine, which showed “generalized hypolordosis with straight cervical spine, C2 though C6, severe spondylosis with large posterolateral bilateral endplate spurring producing left greater than right central stenosis as well as left greater than right foraminal stenosis”
31. EMG report dated 07/16/98 showing “mild acute left C6 radiculopathy superimposed on chronic left C6 radiculopathy”
32. Report dated 11/22/98 indicating right C5/C6 radiculopathy
33. Report dated 06/09/98
34. Report dated 06/09/98 and 02/24/98 report from TD
35. Report dated 10/31/97 from TD
36. Report dated 12/16/96 from TD
37. Functional Capacity Evaluation dated 07/25/96 and 07/26/96
38. Consultation report dated 06/18/96
39. Cervical myelogram report dated 01/06/95 showing left posterolateral osteophytic ridging at C5/C6 mildly pressing on the thecal sac and narrowing the left neural foramen
40. Report dated xx/xx/xx showing some increased insertional activity in the region of the C5/C6 nerve roots on the right side

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The injured employee sustained an injury to her neck on xx/xx/xx while employed as a warehouse worker. She lifted two smaller boxes from a larger one, and apparently the boxes contained steel bolts weighing approximately 60 pounds. Thereafter she had

extensive therapeutic and diagnostic intervention including an anterior cervical discectomy and fusion at the C5/C6 level. She has been monitored by her treating physician ever since. She has had repeat imaging studies as chronicled above. She still complains of pain in her neck ever since her fusion in 1998.

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

The request for a hot tub is, in my opinion, not reasonable or necessary with respect to her cervical spine. There is no medical documentation that shows any beneficial therapeutic effect from this type of passive treatment.

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

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)