



DATE OF REVIEW: 05/13/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy three times per week for four weeks.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

Duly licensed physician in the State of Texas, D.O., fellowship-trained in Pain Management with dual board certification in Anesthesiology and Certificate of Added Qualifications in Pain Medicine, DWC Approved Doctor List Level II

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. Medical records from treating doctor (TD) from 11/29/06 through 03/21/07
2. Independent medical evaluation
3. Records from physical therapist

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This claimant was injured as a result of a work-related motor vehicle accident. He was apparently driving when an automobile lost control in front of him, causing him to hit that vehicle. The claimant was evaluated in the emergency room, and no fractures were found.

He was subsequently treated by with physical therapy and medication. Cervical MRI scan was then performed (date unknown), demonstrating protruded herniated disc at C4/C5 and C5/C6 with a RIGHT disc protrusion at C6/C7 and C7/T1. A left shoulder MRI scan was also performed (date unknown) demonstrating hypertrophy of the

acromioclavicular joint with complete tear of the subscapularis tendon and severe supraspinatus tendinitis.

The claimant then was evaluated by two physicians with recommendations of left shoulder surgery, cervical spine surgery. Instead, the claimant underwent a course of three epidural steroid injections as well as an injection of the left shoulder, after which the claimant was seen by his TD for continuing physical therapy.

The TD apparently performed electrodiagnostic studies demonstrating C5/C6 radiculopathy. However, the report of those results does not indicate which upper extremity was evaluated.

The TD followed up with the claimant ordering "completion of his therapy." No details were provided as to what the prior physical therapy had included nor whether there was any clinical benefit.

The TD then followed up with the claimant documenting his continued neck and upper back pain radiating to the LEFT shoulder as well as intermittent LEFT radicular pain. TD noted the claimant had himself discontinued all of his hypertensive medications. His blood pressure was 206/124 and then 206/122 with a pulse of 110. TD also performed physical examination, demonstrating nonspecific soft tissue tenderness throughout the cervical spine, tenderness over the left acromioclavicular joint, but no neurologic deficits. TD recommended that the claimant go to the emergency room immediately for his hypertensive crisis, documenting that the claimant refused to do that.

An Independent Medical Evaluation was then performed on 02/08/07 and the evaluator documented the claimant's continuing complaints of LEFT neck and upper extremity pain and numbness. The patient was noted to weigh 261 pounds with a height of 69 inches. His blood pressure was 174/120. Physical examination documented symmetrical normal reflexes in the upper extremities as well as no motor or sensory deficits. The evaluation report then stated the claimant was at statutory maximum medical improvement as of that date, awarding a 19% whole person impairment rating.

The TD then followed up with the claimant on 02/21/07, again documenting no focal neurologic deficits on exam. He stated the claimant was "an excellent candidate to begin therapy," despite the fact that the claimant had already apparently had physical therapy.

On 03/07/07 the claimant was seen for "re-evaluation" by physical. Interestingly, there was no mention made of the claimant having completed prior physical therapy or any benefit that may have occurred. Physical examination documented no focal neurologic deficits. The therapist recommended that the claimant begin physical therapy three times a week for four weeks, consisting of passive modalities, ice and heat, electrical stimulation, gentle stretches, stabilization, upper body cycling, and walking. The request for physical therapy was appropriately reviewed by two different physician advisers, both of whom recommended nonauthorization.

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

The documentation clearly indicates in several places that this claimant has already completed an unknown amount of physical therapy with no documentation as to what exactly was done or what benefit, if any, occurred. Therefore, the request for more physical therapy over two years following the alleged work injury is clearly inappropriate. Moreover, the request for physical therapy is for primarily passive modalities, which is certainly not indicated in a claimant whose alleged injury. Finally, the claimant's complaints of LEFT upper extremity complaints are, quite simply, not supported by the MRI scan findings of RIGHT disc herniation, making the necessity for any treatment whatsoever highly questionable. Contralateral subjective pain symptoms are not a valid indication for any type of treatment, including physical therapy. Therefore, since this claimant has apparently had physical therapy with no documented benefit, has nonphysiologic contralateral pain complaints, and is being referred for inappropriate primarily passive modality treatment, there is no medical reason or necessity for the requested physical therapy three times a week for four weeks. Additionally, ODG Guidelines do not support any further physical therapy for this claimant this late into his clinical course.

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.)