



Notice of Independent Review Decision

**DATE OF REVIEW: 08/15/08**

**IRO CASE #:**

**NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Determine the appropriateness of the previously denied request for physical therapy, 2 times a week for 4 weeks.

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

Texas licensed Physical Medicine and Rehabilitation/Pain Medicine Physician.

**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.

The previously denied request for physical therapy, 2 times a week for 4 weeks.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- IRO Reference Letter dated 8/11/08.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 7/24/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 7/23/08.
- Request for a Review by an Independent Review Organization dated 6/23/08.
- Pre-Authorization Determination dated 6/11/08, 5/26/08.
- Reconsideration Request dated 6/3/08.
- History of Present Illness Summary dated 5/16/08.
- Initial Narrative Report dated 5/16/08.
- Electrodiagnostic Assessment Report/ Letter dated 3/14/05.
- Peer Review Report dated 9/23/04.
- Physical Therapy Guidelines (unspecified date).

**PATIENT CLINICAL HISTORY (SUMMARY):**

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Slip and fall

Diagnosis: Cervical disk herniation, cervical myofasciitis, and cervical radiculitis.

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

This male sustained an industrial fall down injury dated xx/xx/xx. On that date, he was walking up a ramp, which was three feet of the ground. He was passing a co-worker, and they bumped into each other. Their feet got entangled and the claimant fell backwards landing on his low back, head, and upper back. He noted acute pain and received physical therapy treatment. He underwent diagnostic imaging studies and a cervical MRI scan demonstrated cervical disk herniations. There was also a lumbar spine MRI scan which demonstrated lumbar disk herniations. He underwent upper extremity electrodiagnostic study that was performed by a chiropractor; however, the date was not specified. Reportedly, this electrodiagnostic study demonstrated a right

C5-C6 radiculopathy, however, these findings were disputed based upon a subsequent March 14, 2005 Physical Medicine Peer Review by MD.

The claimant underwent a subsequent CT/myelogram. He was seen for consultation by various surgeons and pain management specialists. There was some differing opinions regarding surgical management. He declined surgical management and was placed at maximum medical improvement (MMI) as of May 2006. He continued light duty work with lifting restrictions of 25 pounds and limited overhead activity.

He subsequently came under the care of DC as of May 16, 2008. Dr. noted the chief complaint of intermittent mild to moderate cervical pain and stiffness more prominent on the right. He reported intermittent right upper extremity radicular pain and paresthesias. He complained of "knots" of the right shoulder blade and associated headaches. His symptoms were increased with physical activity and heavy lifting. He was prescribed Vicodin and Soma for symptomatic relief. Although he sustained a lower back injury on xx/xx/xx over the past several months, he had reported no pain.

Physical examination findings as recorded by Dr. dated May 16, 2008, demonstrated mild limitation of cervical rotational motion and forward flexion/right lateral flexion. There was moderate limitation of left cervical lateral flexion secondary to pain. There was tenderness and hypertonicity of the bilateral cervical paraspinal musculature. Trigger points were noted within the right cervical, paravertebral, and upper trapezius region. Spurling's maneuver was positive on the right as was shoulder depression. Axial compression of cervical distraction was negative. Thoracic and lumbosacral spine range of motion was reportedly normal. Straight leg raising was negative in the seated and supine positions bilaterally. Neurologic examination was normal with regard to manual muscle testing, deep tendon reflexes, and sensory testing.

Review of the cervical spine, diagnostic X-rays, according to Dr. demonstrated straightening of the cervical lordosis in the lateral projection. There was decreased disk space and spondylosis at the C5-C6 level. There was mild osseous encroachment of intervertebral foramina at C5-C6, C6-C7, and C7-T1 levels on the right. Paracervical soft tissues were unremarkable.

The diagnoses, according to the Dr. included cervical disk herniation, cervical myofasciitis, and cervical radiculitis.

Dr. recommends chiropractic manipulation and physical therapy treatment including electrical muscle stimulation, traction, diathermy, myofascial release, and continuation of previous home exercise program. Dr. requests this treatment twice weekly for four weeks for a total of eight sessions.

In summary, the requested eight physical therapy sessions, 2 times a week for 4 weeks cannot be recommended because physical therapy is not indicated for chronic cervical pain and is not scientifically proven to be a therapeutic benefit for this type of problem. This opinion is based upon Official Disability Guidelines concerning the cervical spine Official Disability Guidelines, I believe that they would not advocate for physical therapy treatment for chronic cervical pain and you can look at the Official Disability Guidelines, chapter regarding Cervical Spine Treatment as the original work injury occurred on xx/xx/xx, which we are now xxxx years post injury, therefore, the requested physical therapy would not be medically indicated according to Official Disability Guidelines.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

**X** ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.  
Treatment Index, 6<sup>th</sup> Edition, 2008, Neck-Physical therapy.

- 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).