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Notice of Independent Review Decision

DATE OF AMENDED REVIEW: 03/11/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Items in Dispute: Physical therapy two times a week for six weeks (twelve visits).

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

Board Certified in Physical Medicine & Rehabilitation

REVIEW OUTCOME

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

Denial Overturned

Twelve (12) sessions of supervised therapy over a six week timeframe is approved.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Lumbar MRI report dated 02/08/07.
2. Cervical MRI report dated 04/12/07.
3. Documentation from Dr. dated 04/24/07, 05/09/07, 05/16/07, 05/30/07, 05/31/07.
4. Documentation from Dr. dated 07/30/07.
5. Documentation from Dr. dated 09/11/07.
6. Documentation from Dr. dated 10/29/07, 11/09/07, 01/21/08, 02/25/08.
7. Documentation from Dr. dated 12/18/07.
8. ***Official Disability Guidelines***

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records available for review document that the employee sustained a fall in the workplace on xx/xx/xx. The employee was working as a xx and was

walking backwards guiding a plane to the terminal when he tripped over chucks that were on the ground.

A lumbar MRI was obtained on 02/08/07, which revealed findings consistent with disc degenerative changes at the L5-S1 level and at the L4-L5 level.

A cervical MRI was accomplished on 04/12/07 and revealed evidence for a disc bulge at the C5-C6 and C6-C7 levels. Additionally, there was evidence for moderate to severe spinal stenosis at the C5-C6 level.

The employee was evaluated by Dr. on 04/24/07. An electrodiagnostic assessment of the upper extremities was obtained. This study disclosed findings consistent with a mild acute right C6 radiculopathy, and also there was evidence for a mild upper extremity median neuropathy consistent with carpal tunnel syndrome.

On 05/09/07, Dr. performed a right C5-C6 and C6-C7 transforaminal epidural steroid injection.

On 05/16/07, Dr. indicated that the injection provided on 05/09/07 gave the employee a reduction in pain symptoms of approximately 50%.

On 05/30/07, Dr. performed a right C5-C6 and C6-C7 transforaminal epidural steroid injection.

An electrodiagnostic assessment was performed by Dr. on 05/31/07. This study obtained on the lower extremities revealed findings consistent with a bilateral L4-L5 radiculopathy.

Cervical spine surgery was performed by Dr. on 07/30/07. Surgery consisted of an anterior cervical discectomy and decompression of the spinal canal at the C5-C6 and C6-C7 levels.

The employee was evaluated by Dr. on 09/11/07. Dr. recommended that consideration be given for a lumbar discogram, as the employee was with persistent complaints of low back pain that was felt to be related to a discogenic pain source.

The employee was evaluated by Dr., a chiropractor, on 10/29/07. It was documented that past medical records were not available for review.

Dr. reevaluated the employee on 11/09/07. It was again recommended that previous medical records be obtained for review.

The employee was evaluated by Dr. on 12/18/07. It was recommended that the employee receive treatment in the form of a comprehensive physical therapy program to the cervical spine and lumbar spine.

Dr. evaluated the employee on 01/21/08. It was recommended that the employee receive treatment in the form of rehabilitation services. The employee was diagnosed with status post cervical fusion surgery and lumbar radicular syndrome with bilateral radiation.

Dr. reevaluated the employee on 02/25/08. It was again requested that the employee receive treatment in the form of supervised rehabilitation services.

Of note, the available records do not appear to indicate that the employee received any supervised rehabilitation services after the surgical procedure on 07/30/07. However, the records do indicate that the employee received access to supervised rehabilitation services after the date of injury. Specifically, a note from Dr. dated 12/18/07 indicated that prior treatments included multiple injections, physical therapy, use of a TENS devise.

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

The records available for review do not document that the claimant received any access to supervised rehabilitation services after the surgical procedure of 07/30/07. **Official Disability Guidelines** would support ten sessions of supervised rehabilitation services over a maximum of a six week timeframe. Hence, the 12 sessions requested would be reasonable. The available records do not indicate that there were any postoperative complications. If there were no postoperative complications, generally it is realistic to expect that a fusion should be healed by the time one is this far removed from the date of injury. If it has been determined that the fusion site is healed, then up to 12 sessions of supervised rehabilitation would be reasonable and appropriate per the above noted reference.

Therefore, based upon the medical records available for review, twelve sessions of supervised rehabilitation services over a six week timeframe would be considered reasonable and appropriate.

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

1. ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES