

Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 10/21/2008  
**IRO CASE #:**

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

1. Physical therapy 3 X week X 4 weeks (12 visits) including 97032, 97012, 97140, and 97024

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer attended San Diego State University before graduating from the Palmer's College of Chiropractic West in 1989. He has been in private practice in San Diego County for over 14 years. He also works as a team chiropractor for a local high school. He has also worked as a peer reviewer doing Worker's Compensation and Personal Injury Prospective, Retrospective, Forensic, and Chart Reviews since 10/2000. His post graduate studies include various seminars on cervical spine "whiplash" syndrome, arthritis, neurology, radiology, sports medicine, and worker's compensation.

**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)

1. Physical therapy 3 X week X 4 weeks (12 visits) including 97032, 97012, 97140, and 97024 Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. IRO request form dated 10/7/2008
2. Clinical note dated 10/2/2008
3. Clinical note by RN, dated 9/25/2008
4. Clinical note dated unknown
5. Clinical note by RN, dated 9/10/2008
6. Utilization review dated unknown
7. Request for A review dated 10/6/2008
8. Pre authorization request dated 9/25/2008
9. Initial narrative report by DC, dated 8/30/2008
10. Clinical note dated 8/25/2008
11. MR spine dated 8/11/2006
12. MRI L spine dated 6/10/2008
13. Clinical note by RN, dated 9/10/2008
14. Outpatient reconsideration by RN, dated 10/2/2008
15. Clinical note dated 10/7/2008
16. Notice dated 10/8/2008
17. Clinical note dated unknown
18. Clinical note dated 10/8/2008
19. Notice to utilization review dated 10/8/2008
20. Clinical note dated 10/8/2008
21. Clinical note dated unknown
22. Clinical note dated unknown
23. Pre-authorization request dated 9/4/2008
24. Clinical note dated 8/25/2008

Name: Patient\_Name

- 25. MRI C spine dated 8/10/2008
- 26. MRI L spine dated 8/10/2008
- 27. Official Disability Guidelines (ODG)

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The injured employee is a male who is diagnosed with cervicalgia, cervical radiculitis, cervical sprain, lumbalgia, lumbar radiculitis, and lumbar sprain/strain. He presents with intermittent moderate to severe pain, stiffness, and muscle spasms affecting the cervical, thoracic and lumbar spine especially the right and left paraspinal areas. The cause of the injury was due to a hood that slammed against the patient's back due to high winds. A MRI shows degenerative disc disease at L2/3, L3/4, and L4/5.

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

The claimant was involved in a work injury on xx/xx/xx. The injury was described as "a hood that was actually closed by high winds that caused that hood to land on the patient's back." The claimant initially presented to the company's workers compensation doctor. The type and nature of treatment rendered this claimant by this provider was not available for review. The nurse case manager summary suggests that the claimant received 12 treatments. On 8/25/2008 the claimant was evaluated by his medical provider. At that time it was noted that the claimant had pain down the legs and "can't bend." It was further noted that the claimant was "going to PT-not helping." The claimant was diagnosed with cervical and thoracic pain and lumbosacral sprain. The recommendation was for a referral for chiropractic evaluation. On 8/30/2008 the claimant presented to the office of Dr. DC. At that time it was noted the claimant continued to have intermittent moderate to severe pain, stiffness and muscle spasms affecting the cervical, thoracic and lumbar spine. The claimant also noted episodes of radiating symptoms of pain, numbness and tingling in the left leg. The claimant was diagnosed with cervicalgia with cervical myofascitis syndrome, cervical radiculopathy, thoracic myofascitis, lumbalgia, lumbar radiculopathy, and lumbar radiculitis. A request for 12 treatments consisting of myofascial release, electrical muscle stimulation, traction, and diathermy was submitted.

The requested passive therapies are not supported by ODG guidelines. ODG guidelines give the requested passive physiotherapy modalities a "not recommended" rating. At the time of this request the claimant was nearly 2 months post-injury and well past the acute phase of care where passive therapy could be considered appropriate. Moreover, the requested treatment at 3 times per week for 4 weeks exceeds ODG guidelines. The ODG guidelines low back chapter indicates "10 visits over five weeks" can be considered appropriate for the diagnosis of lumbar sprain. The requested 12 treatments exceed this guideline. Given the fact that the requested 12 treatments exceeds ODG guidelines and that the requested therapeutic intervention consists entirely of passive therapy that is not supported by ODG guidelines, the medical necessity for the requested 12 treatments was not established. The previous denial is upheld.

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

- 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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)