

PRIME 400 LLC
240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 29, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3x a week for 4 weeks, 97110, 97140 (G0283 PNR) cervical

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

M.D., Board Certified Orthopedic Surgeon

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 reviewer finds that medical necessity does not exist for Physical therapy 3x a week for 4 weeks, 97110, 97140 (G0283 PNR) cervical.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 7/25/08, 8/7/08
Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back, Cervical, Shoulder-Physical therapy
CT cervical spine, 04/28/08
X-rays, 05/29/08
Office notes, Dr. , 05/29/08, 06/20/08, 07/28/08, 08/25/08, 08/11/08
CT lumbar spine, 06/27/08
EMG/NCV, 07/02/08

Ultrasound studies, Dr. , 07/24/08
Office note, Dr. , 07/30/08
Physical therapy notes, 05/29/08-08/11/08
CT Brain, 04/28/08
Office note, Dr. , 08/12/08
Therapy, 06/06/08
Consents, 07/02/08, 07/29/08
Prescription, 06/20/08, 07/07/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female injured on xx/xx/xx when she fell from a rolling chair and struck her head. She had a period of loss of consciousness and was taken to the emergency department. The xx/xx/xx CT of the cervical spine showed bony nerve root canal narrowing at C4-5 and C5-6 and posterior spurring flattened the thecal sac resulting in mild canal stenosis. There was a moderate broad based protrusion at C5-6. The 05/29/08 x-rays documented mildly decreased disc height at C3-4, 4-5, 5-6 and 6-7. There was a possible pars defect at L4 and grade I spondylolisthesis. Left shoulder x-rays documented mild calcification of the acromioclavicular joint

On 05/29/08 Dr. saw the claimant for pain and numbness in the left face with constant headache, achy intermittent cervical pain, lumbar pain radiating to the thoracic region, pain in the left shoulder and swelling of the left knee. On examination there was spasm of the cervical spine with limited motion and negative Spurling. Left shoulder motion was limited with positive impingement. She had decreased sensation in left C5, 6 and T1 and 2. Upper extremity reflexes were 2plus. Tenderness was noted at T1-2. There was lumbar spasm, limited motion and positive left straight leg raise. The impression was lumbar disc disorder, cervical disc protrusion, left shoulder internal derangement and head injury with facial numbness. Dr. recommended therapy, Celebrex, Darvocet and Diazepam.

A 06/27/08 CT of the lumbar spine showed an L3-4 3mm bulge mildly impinging the thecal sac, moderate facet degeneration and hypertrophy of the ligamentum flavum causing mild canal stenosis with moderate narrowing of the lateral recesses. At L4-5 there was degenerative spondylolisthesis and severe facet hypertrophy and at L5-S1, facet hypertrophy. A 07/02/08 EMG/NCV documented polyneuropathy.

On 08/25/08 Dr. noted the claimant had constant lumbar pain with radiation to the legs, constant cervical and left shoulder pain and reported swelling in the legs and arms. The examination documented a negative Spurling, limited motion and tenderness of the cervical spine. She had positive left shoulder impingement. There was decreased light touch as before, mild thoracic tenderness, limited lumbar motion, positive left straight leg raise and pitting edema. Therapy was requested.

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

The claimant is a xx year old female with degenerative changes of the cervical spine, left shoulder and lumbar spine. Review of the records notes that she has had these complaints since an injury approximately five months ago. Records show that the

claimant attended therapy from 05/29/08 through 08/11/08 for 25 sessions. Pain complaints at the end of that time were ongoing and without a significant change in the VAS rating. Examinations by Dr. have remained unchanged as well with no appreciable decrease in pain or increase in motion. Given these findings it is not felt that any additional formal therapy would lead to cessation of pain or significant improvement in motion. Any additional therapy would clearly far exceed ODG recommendations and the physical examinations, progress and objective findings do not support that the claimant is an outlier to the recommendations in ODG. The reviewer finds that medical necessity does not exist for Physical therapy 3x a week for 4 weeks, 97110, 97140 (G0283 PNR) cervical.

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back, Cervical, Shoulder-Physical therapy

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#), including assessment after a "six-visit clinical trial".

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0):

9 visits over 8 weeks

Sprains and strains of neck (ICD9 847.0):

10 visits over 8 weeks

Displacement of cervical intervertebral disc (ICD9 722.0):

Medical treatment: 10 visits over 8 weeks

Rotator cuff syndrome/impingement syndrome (ICD9 726.1; 726.12):

Medical treatment: 10 visits over 8 weeks

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)**