



**DATE OF REVIEW:** 4/30/09  
**Date Amended:** 5/13/09

**PATIENT NAME:**

**IRO CASE #:**

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

Determine the appropriateness of the previously denied request for active and passive therapy and rehabilitation with 97140, 97530, G0283, 97110, 97035 and 97112.

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

Texas licensed Family 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 active and passive therapy and rehabilitation with 97140, 97530, G0283, 97110, 97035 and 97112.

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

1. Texas department of Insurance Fax Cover Sheet dated 4/27/09.
2. Notice to utilization Review Agent of Assignment of Independent Review Organization Sheet dated 4/27/09.
3. Notice to Inc. of Case Assignment Sheet dated 4/27/09.
4. Confirmation of receipt of a Request for a Review by an Independent Review Organization (IRO) Form dated 4/27/09.
5. Fax Cover Sheet/Authorization Request Note dated 1/13/09.
6. Request Form/Request for a Review by an Independent Review Organization Form dated 1/13/09, 9/19/08.
7. Request for Certification Report dated 9/15/08, 8/28/08.
8. Patient Medical History Note dated 9/4/08.
9. Letter of Medical Necessity and Pertinent Doctor Note Sheet dated 8/21/08.
10. Prescription for Course of Treatment Authorization Sheet dated 8/21/08.
11. Script for Order Form dated 8/19/08.
12. Workers' Comp History and Physical examination Summary dated 8/19/08.
13. IRO Decision description Summary (unspecified date).

There were no guidelines provided by the URA for this referral.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

**Age:**

**Gender: Female**

**Date of Injury: xx-xx-xx**

**Mechanism of Injury: Forcefully opening a door.**

**Diagnosis: Cervical sprain.**

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

This is a female who was injured on xx-xx-xx. Her diagnoses were cervical, thoracic and shoulder sprain. It should be noted that the case went to peer review twice and a request for therapy for the low back was reviewed. It was denied although provider contact was not made. When the medical records were reviewed, it became apparent that the patient's primary injury was to the cervical spine and not the neck. This reviewer does, however, believe that treatment for the neck was warranted, although the purpose of this review was to address low back treatment. The patient was evaluated M.D. on xx/xx/xxxx, who documented that she had cervical pain related to her occupational injury. It was located in

the neck on the left and radiated to the shoulder and left arm. She had had two visits with a chiropractor, Dr. and found improvement with her left arm symptoms with treatment. She reported that massage helped and she would awaken from sleep at night with neck pain. She sometimes had difficulty sleeping due to pain as well. Her physical examination related to the neck revealed decreased right cervical range of motion with pain felt in the left cervical paraspinal and upper trapezius region. She had mildly limited lateral bending. Upper extremity strength was 5/5 bilaterally and reflexes at the biceps, triceps, and brachioradialis were symmetric. Palpation of the cervical paraspinal muscles revealed diffuse tenderness and trigger points in the trapezius levator scapula, medial scapular border, and something of illegible. She submitted a prescription for treatment for the cervical and thoracic spine. Her prescription did not include a mention of any lumbar diagnosis. Continued treatment with Dr. was listed under the treatment recommendations. Dr. 12/30/08 re-assessment also mentioned neck, upper back, shoulder and left arm symptoms, but did not make any mention of the low back. Dr. evaluated the patient and requested treatment on August 21, 2008, listing the objectives of decreasing pain, muscle spasms, improving range of motion, and strength and a decreased nerve root compression in the involved areas. A letter of medical necessity from him dated August 21, 2008, listed the CPT Codes above for treatment of the cervical spine. Again, there was no mention that she had lumbar spine complaints or required treatment for the lumbar spine. During Dr. first evaluation on July 18, 2008, he documented complaints of upper and mid back pain, and left arm pain. There was no mention of low back symptoms. When his progress notes were reviewed, it appears as though the patient was treated by him on numerous occasions from July 2008 through January 2009 and his progress notes did, in fact include low back complaints on at least 15 occasions. The first low back reference the reviewer could find was from his 10/3/09 progress note, when low back pain was listed as a subjective complaint. The first evidence of low back treatment the reviewer could find was on November 11, 2008, when she received lumbar traction. The other progress notes did not specifically mention that the low back was treated. However, lumbar traction was not one of the services/CPT codes in question. Dr. wrote a letter of appeal (for IRO) dated September 22, 2008, requesting that he be reimbursed for therapy for the cervical spine NOT the lumbar spine. In fact, he specifically stated, "Also, Dr. and Dr. state in their reports that has sustained a lumbar sprain/strain (ICD9 847.2) with her injury and that is not correct...She injured her cervical, thoracic and both shoulders...I am requesting for initial therapy on to be approved for her cervical, thoracic and shoulder areas." It's not clear to this reviewer how the lumbar spine is related to the occupational injury since the first mention of lumbar complaints was not documented in the medical records until four months after the injury. Dr. records never documented lumbar complaints. According to the Official Disability Guidelines, for a diagnosis of lumbar sprain, up to "10 visits over 8 weeks" of physical therapy are allowed. Although Dr. is a chiropractor, he was not requesting manipulation, so the physical therapy guidelines were used. He was requesting only therapy and rehabilitation. However, it does not appear as though any of the requested CPT codes were actually provided for the lumbar spine, therefore, the denial for services for the lumbar spine was upheld. The records indicate that only the cervical spine was treated with 97140, 97535, G0283, 97110 and 97035. Furthermore, according to Dr. letter of appeal, he specifically stated he was not appealing treatment for the lumbar spine. This reviewer attempted to modify the determination to

include treatment for only the cervical spine, since this appeared to be the most practical solution to the problem at hand. Nevertheless, this determination only relates to lumbar related treatments.

**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  
Official Disability Guidelines, Web-Based Version, 7th Edition, 2009, Low Back Physical Therapy.
- 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)**