

# I-Resolutions Inc.

An Independent Review Organization  
71 Court Street  
Belfast, ME 04915  
Phone: (512) 782-4415  
Fax: (512) 233-5110  
Email: [manager@i-resolutions.com](mailto:manager@i-resolutions.com)

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/29/2009

**IRO CASE #:**

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

Physical Therapy 12 Sessions to Cervical Spine

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Board Certified in Pain Management

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines and Treatment Guidelines  
Adverse Determination Letters, 3/23/09, 4/8/09  
Lifecare Center, 2/6/09  
MD, 1/27/09, 12/8/08, 6/21/07, 6/7/07,  
MD, 12/19/07  
MRI Cervical Spine, 12/11/07  
History & Physical, Medical Center, 5/6/07  
Discharge Summary, 5/6/07  
MD, 1/3/07, 10/31/06

**PATIENT CLINICAL HISTORY SUMMARY**

This is a woman injured in xx/xxxx. She underwent a cervical laminectomy and resection of an endometrioma/syrinx from C2-C7 on 4/9/07. She had a post op MRSA infection and surgical debridement. She received 21 physical therapy sessions after surgery, followed by additional therapy sessions and then she was in a chronic pain program that included additional therapy.

Dr. wrote that she had a disc herniation aggravating the constant neck pain and advised additional therapy. He wrote on 12/18/08 that "She does not have any acute deficit." There is a request from Life Care Center for additional therapy at 3 times a week for 4 additional weeks. Her December 2007 MRI showed cervical spondylosis and moderate to severe foraminal narrowing at C5/6 and C6/7. There is a suspicion for residual tumor in the cervical spine.

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

Dr. wrote 1/27/09 that this patient had a disc causing the additional pain. The only MRI report provided with the records occurred 6 months post surgery in 2007. This patient is having pain, but Dr. has indicated in the records that there was no acute neurological loss.

The ODG permits some therapy post cervical laminectomy: Post Laminectomy Syndrome (ICD9 722.8): 10 visits over 6 weeks. She has completed more than twice the amount of therapy recommended by ODG.

Further, she has also participated in a chronic pain program. The ODG states that no further outpatient medical rehabilitation would be recommended following a CPMP. "11) At the conclusion and subsequently, neither re-enrollment in nor repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury."

In the absence of any new neurological problem, there is no justification for the additional therapies in the records provided for this review. The request does not meet the guidelines. The reviewer finds that medical necessity does not exist for Physical Therapy 12 Sessions to Cervical Spine.

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

- ACOEM-AMERICA 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)