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## Notice of Independent Review Decision

**DATE OF REVIEW:** 4/2/09

**IRO CASE #:**

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

The services under review include 12 sessions of physical therapy performed by a Doctor of Chiropractic.

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

The reviewer is a Doctor of Chiropractic who has been practicing for greater than 10 years.

### **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)

The reviewer disagrees with the previous adverse determination regarding all services under review.

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

Records were received and reviewed from the following parties:  
Injury Center

These records consist of the following (duplicate records are only listed from one source): Injury Center: 12/30/08 notice to appear for medical exam, 2/9/09 report by MD, 3/12/09 report by ICH, 1/8/09 through 2/12/09 re-exams by ICH, 2/10/09 CMT and ROM report, office note by MD of 1/19/09, CT of C-spine with post myelogram of 12/31/08, 2/10/09 neurodiagnostic testing and 8/13/07 to 9/27/07 procedure reports.

2/19/09 rehab request form, 1/22/09 report from MS, CMT and ROM report of 11/21/08, 7/17/08 and 11/21/08 patient re-exams by ICH.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured while working on or about xx/xx/xx. He is a male who is right handed. His injury occurred when he fell off a ladder. He had spinal surgery in August of 2007 by Dr. This included C4, C5 and C6 corpectomy with bilateral foraminotomies at C3/4, C4/5, C5/6 and C6/7.

In February of 2009, the patient was seen for an RME with Dr. Neurological exam is marked for decreased sensation and lack of UE reflexes. ROM is lacking in all cardinal planes of movement. Dr. opines that further treatment is necessary and that he completes a further 9-12 sessions of PT even though this is outside of the normal bounds of the ODG.

The patient suffered an exacerbation of symptoms while performing his at home therapy program in January of 2009. The records reflect that he discontinued stretching for a time and is currently feeling somewhat better.

The carrier reviewing physicians indicate there has been no substantial improvement in this patient's care. Therefore, they are recommending denial of the requested services based upon the ODG.

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

The reviewer opines that the ODG does not adequately address a situation such as this patient presents. The reviewer quotes the ODG in that it "is presented as an ideal case plan, indicating selected interventions recommended for each visit, along with timing for these visits. The Treatment Planning section is only a recommendation. It is NOT to be used as a rigid protocol applied in all cases." The ODG allows for up to 24 therapy sessions for a single level fusion; however, this gentleman has had a 4 level fusion. It does allow for up to 48 therapy visits in severe cases of spinal injury with neural involvement. This would appear to more adequately represent this gentleman's situation. Furthermore, the Insurance's required medical examination doctor opined that this gentleman required further PT within the range that is being requested here after a thorough physical examination. Mayer indicates that interdisciplinary rehabilitation should be performed after a fusion surgery which yields greater chances of success for a patient's outcomes.

Therefore, it is the reviewer's opinion that the requested therapy services are medically necessary at this time based upon the records provided. The ODG treatment protocols do not directly address this injury in a thorough manner; therefore, as per DWC rule 133.308 (p) (G) (i) he is applying both the ODG and medically accepted literature/research to base the opinion.

**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) Mayer TG, Anagnostis C, Gatchel RJ, Evans T. Impact of functional restoration after anterior cervical fusion on

chronic disability in work-related neck pain. Spine J. 2002 Jul-Aug;2(4):267-73

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**