

Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: MAY 4, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed 12 (3X wk X 4 Wks) sessions of PT (97110,97140, G0283)

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

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is licensed by the State of Texas and is engaged in the practice of chiropractic on a full-time basis.

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)

| Primary Diagnosis | Service being Denied | Billing Modifier | Type of Review | Units | Date(s) of Service | Amount Billed | Date of Injury | DWC Claim# | IRO Decision |
|-------------------|----------------------|------------------|----------------|-------|--------------------|---------------|----------------|------------|--------------|
| 847.2 | 97110, G0283, 97140 | | Propsp | 12 | | | xx-xx-xx | | Upheld |
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INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-18 pages

Respondent records- a total of 33 pages of records received to include but not limited to:
TDI letter 4.13.09; letters 3.6.09, 2.12.09; Spine and Rehab notes 11.25.08-4.9.09

Requestor records- a total of 44 pages of records received to include but not limited to:
TDI letter 4.13.09; Spine and Rehab notes 11.25.08-4.9.09; Request for an IRO forms; letters 3.6.09; MRI L-spine 11.18.08; MRI C-spine 11.18.08; NCV study 1.22.09; Cervical and Lumbar Extremity evoked potential study 1.23.09; report, Dr. 4.3.09; Dr, note 4.8.09

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a non-certification of a request for an additional 12 sessions of physical therapy. It was reported that the injured employee had undergone 10 sessions of physical therapy and there was some noted improvement. The pain levels reportedly decreased, the range of motion increased and there was an increase in the ability of activities of daily living. The apparent reason for the non-certification was that "sufficient supervised therapy" had been completed and the injured employee should be transitioned to a home based program.

A reconsideration was filed by the requestor. The most recent progress notes from the requesting provider begin with a subsequent evaluation dated January 30, 2009 noting ongoing complaints of constant neck pain. The reported mechanism of injury was an MVA. It appears that the cervical spine injury was treated with 10 sessions of physical therapy and then 12 sessions of physical therapy for the lumbar spine injury was planned. Imaging studies of the cervical and lumbar spine (MRI) noted ordinary disease of life degenerative changes. Electrodiagnostic studies reported a C6 motor radiculopathy. Prior progress notes noted essentially the same physical examination and pain levels. The MRI reports and EMG assessment were reviewed. No acute pathology was noted. Additionally, the EMG assessment did not include any paraspinal muscle testing in the cervical spine, thereby negating the assessment of a possible C6 radiculopathy.

Dr. completed a pain management consultation on January 29, 2009. The assessment was low back pain with radiculitis. Transforaminal epidural steroid injections were recommended (no evidence of a disc lesion compromising a nerve root or verifiable radiculopathy noted). The epidural steroid injections were completed on April 3, 2009.

Dr. read the MRI reports differently than the radiologist indicating that there was as C4/5 and C5/6 disc herniation with nuclear protrusion and a C3/4 contained disc lesion. Dr. also felt that there was a contained L4/5 disc herniation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

As noted in the Division mandated Official Disability Guidelines, physical therapy is a recommended approach in the treatment of a soft tissue cervical spine injury and lumbar spine injury. However, it is also noted that this is to be augmented with a home based program, and the records presented for review do not reflect that augmentation has been suggested. Further, there were no notes from the physical therapist outlining the modalities delivered and the relative efficacy of the program implemented. Commonly accepted and utilized outcome measurement tools that outline changes in the patients perceived subjective complaints such as the Neck Disability Index and Oswestry questioners are not utilized. As noted in the ODG, up to 10 sessions over 8 weeks are suggested for the cervical and lumbar spine injury. The ODG recommended course of PT has been completed, however, the most recent progress notes do not indicate and functional utility or efficacy in terms of improved functionality, or significant pain reduction from the beginning of the therapy to the end of the sessions completed. Given the reading of the MRI reports (both by the radiologist and Dr.), the amount of physical therapy endorsed by the literature would be unchanged. Dr. who performed a peer to peer with Dr. on 2/11/09 recommended approval of 4 sessions of PT 2x/wk x 2weeks, treatment to include 97110 and 97140. Dr. did not agree to the modified PT approval because of the elimination of electric muscle stimulation. Lastly, physical therapy is indicated in the acute phase of soft tissue injuries to the cervical and lumbar spine. In that this was delivered, and noting the date of injury this is no longer an acute situation. According to the ODG, at this time nothing more than a home-based, self-directed exercise program emphasizing overall conditioning and fitness would be warranted.

Ref: *Official Disability Guidelines, (ODG), 2007, 5th ed.*

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES