



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

Notice of Independent Review Decision-WC

**CLAIMS EVAL REVIEWER REPORT - WC**

**DATE OF REVIEW: 9-4-09**

**IRO CASE #:**

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

Physical therapy for the lumbar spine 3 times a week x 4 weeks

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

American Board of Orthopaedic Surgery-Board Certified

**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.

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

- 1-29-09 MD., provided Peer Review.
- 5-28-09 DO., office visit.
- 8-4-09 MD., Utilization Review.
- 8-18-09 MD., Utilization Review.

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

Medical records indicate the claimant was struck by a vehicle driven by a citizen. He was initially seen with a complaint of left elbow pain, left wrist pain, right knee pain and left calf pain. He had x-rays performed, which were unremarkable. An MRI scan dated xx/xx/xx was reported to show soft tissue swelling only. MRI of the right knee dated 6-6-08 shows joint effusion and probably a proximal MCL rupture. The claimant was seen by Fr., on 6-10-08. The radiograph showed possible occult scaphoid fracture.

The claimant underwent incision and drainage of an infected left olecranon bursa on 7-11-08. A cervical MRI dated 7-25-08 showed a right sided disc herniation at C6-C7 level.

An MRI of the right knee dated 8-1-08 showed a grade I sprain of the medial collateral ligament.

The claimant was seen by Dr. on 8-19-08 and reported significant weakness in one upper extremity. It was felt the claimant had a cervical disc herniation and surgical treatment was recommended.

Medical records reflect the claimant underwent a C3-4 fusion December 17, 2008. The claimant now has lumbar complaints. MRI according to the clinician shows annular tears at L3-L5 with herniation causing right stenosis L3-L4 and left stenosis at L4-L5. The claimant has been riding his bicycle as a but now has constant back pain and intermittent radicular complaints in both legs. His medication includes Vicodin.

On 1-29-09, MD., provided a Peer Review. It was his opinion that because there is no documentation of spinal complaints until 7-8-08, that it was most unlikely that the claimant sustained an injury to this spine. The compensable diagnosis appear to be

related to some degree of a concussion, a left elbow contusion, a left wrist strain and right wrist sprain and a left calf contusion. The evaluator was unable to attribute the findings on his cervical MRI to the event of 6-1-08.

On 5-28-09, the claimant was evaluated by, DO. The claimant reports that he is doing well as far as his neck is concerned. The evaluator did not recommend surgery. However, his back pain has become more progressive. He is getting radiculopathy. The evaluator felt that the claimant will require surgery in the future.

On 8-4-09, MD., provided an adverse determination for the requested physical therapy. The evaluator noted that he called the doctor's office. Spoke with on 8/3/09. The treating physician is not available this week. The date of injury is listed as 6/1/08. There is a documented diagnosis of a lumbar radiculopathy. The records available for review do not document that there are any new changes on neurological examinations. The current request would appear to be for therapy services to the lumbar region. At the present time, for the described medical situation. medical necessity for this request is not established. The Official Disability Guideline would support an expectation that a person could performs a proper non supervised rehabilitation regimen when a person is this far removed from the onset or symptoms and when therapy services have previously been provided. As a result, per criteria set forth by the above noted reference, medical necessity for this specific request is not established.

On 8-18-09, MD., provided an adverse determination. The evaluator noted that the request as it stands exceeds typical recommendations for physical therapy for this issue. The clinician has not described the clinical necessity for additional formal therapy. The claimant is riding his bike as part of his job requirements at this point and may not require lumbar therapy.

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

MEDICAL RECORDS REFLECT A CLAIMANT STATUS POST A MOTOR VEHICLE - PEDESTRIAN ACCIDENT. HE INJURED HIS LEFT SHOULDER, ELBOW, WRIST AND CERVICAL SPINE. HE HAS UNDERGONE SURGERY FOR THE CERVICAL SPINE AND INCISION AND DRAINAGE FOR A LEFT OLECRANON BURSA. HE LATER COMPLAINED OF LOW BACK PAIN. THE CLAIMANT WORKS AS A POLICE OFFICER AND RIDES A BIKE AS PART OF HIS JOB REQUIREMENT. BASED ON THE MEDICAL RECORDS PROVIDED, THERE IS NO INDICATION FOR PHYSICAL THERAPY TO THE LUMBAR SPINE AT THIS JUNCTURE, OVER A YEAR AFTER THE ORIGINAL INJURY. THERE IS NO INDICATION AS TO WHY THE CLAIMANT CANNOT PERFORM A HOME EXERCISE PROGRAM. THEREFORE, THE MEDICAL NECESSITY FOR PHYSICAL THERAPY OVER A YEAR AFTER THE ORIGINAL INJURY AND WITH THE CLAIMANT RIDING HIS BIKE AS PART OF HIS WORK DUTIES, IS NOT ESTABLISHED AS MEDICALLY NECESSARY.

**ODG-TWC, last update 8-21-09 Occupational Disorders of the Low Back – physical therapy:**

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):

10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846):

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)