



---

Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

### **Notice of Independent Review Decision**

**DATE OF REVIEW:** 01/19/10

**IRO CASE #:**

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

12 sessions of physical therapy three times a week for four weeks

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

Board Certified in Orthopedic Surgery

**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.

12 sessions of physical therapy three times a week for four weeks - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

An Employee's Report of injury form dated 09/11/09

An evaluation with M.D. dated 09/14/09

X-rays of the cervical spine, right wrist, thoracic spine, and lumbar spine interpreted by M.D. dated 09/14/09

Discharge instructions from an unknown provider (signature was illegible) at xxxxx dated 09/14/09

DWC-73 forms from, D.O. dated 09/28/09, 10/06/09, and 10/14/09

Evaluations with Dr. and D.O. dated 09/28/09, 10/06/09, and 10/14/09

Physical therapy with, P.T. dated 09/29/09, 10/01/09, 10/07/09, 10/12/09, 10/13/09, and 10/15/09  
X-rays of the cervical and lumbar spine interpreted by M.D. dated 10/02/09  
An evaluation with M.D. dated 10/02/09  
Laboratory studies dated 10/02/09  
A discharge report from an unknown nurse (signature was illegible) dated 10/02/09  
A CT scan of the cervical spine interpreted by Dr. dated 10/02/09  
PLN-11 forms from the insurance carrier dated 10/14/09, 10/28/09, 10/29/09, and 11/09/09  
An EMG/NCV study interpreted by M.D. dated 10/29/09  
An evaluation with Dr. dated 10/29/09  
Evaluations with M.D. dated 10/30/09 and 11/16/09  
A physical therapy evaluated with Dr. dated 11/16/09  
Preauthorization requests from Dr. dated 11/24/09 and 12/07/09  
An evaluation with M.D. dated 11/25/09  
Letters of non-authorization, according to the Official Disability Guidelines (ODG), dated 12/01/09 and 12/14/09  
A request for reconsideration letter from Dr. dated 12/04/09  
An evaluation with M.D. dated 12/07/09  
Computerized Muscle Testing (CMT) and Range of motion testing dated 12/07/09  
A letter of appeal from Dr. dated 01/08/10

### **PATIENT CLINICAL HISTORY**

X-rays of the cervical spine, right wrist, thoracic spine, and lumbar spine performed on 09/14/09 were unremarkable. On 09/28/09, Dr. recommended physical therapy, a Medrol Dosepak, and Ultracet. Physical therapy was performed with Ms. on 09/29/09, 10/01/09, 10/07/09, 10/12/09, 10/13/09, and 10/15/09. X-rays of the cervical and lumbar spine interpreted by Dr. on 10/02/09 showed a posterior disc osteophyte complex at C4-C5 and mild multifactorial central canal stenosis at L4-L5 with degenerative changes. A CT scan of the cervical spine on 10/02/09 showed the same findings as the x-rays. On 10/06/09, Dr. recommended continued physical therapy, Motrin, Flexeril, and a referral to a PMD for evaluation of fibromyalgia and major depression. On 10/14/09, the insurance carrier stated they disputed entitlement of medical treatment and disability benefits for the depression, endometriosis, hypertension, asthma, hypothyroidism, a spastic colon, cervical disc osteophytes, cervical stenosis, and lumbar foraminal stenosis. On 10/28/09, the insurance carrier disputed that the compensable injury extended to and included disc bulges and osteophyte formation in the lumbar spine and vascular pelvic calcifications. An EMG/NCV study interpreted by Dr. on 10/29/09 showed cervical radiculopathy at C5-C6 on the left with an incidental finding of bilateral median neuropathy at the wrist. On 10/30/09, Dr. recommended Hydrocodone, Ultram ER, Skelaxin, Feldene, and physical therapy. On 12/01/09 and 12/14/09,

Forte wrote a letter of non-authorization for 12 sessions of physical therapy. On 12/04/09, Dr. wrote a request for reconsideration letter for physical therapy.

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

The patient suffered minor sprains/strains in her cervical and lumbar spines. The patient has already been treated with nine visits of physical therapy and has reached the point at which the ODG does not recommend further treatment. There has been no evidence of a significant injury. The patient had mild preexisting degenerative changes. Therefore, the requested 12 sessions of physical therapy three times a week for four weeks would be neither reasonable nor necessary and the previous adverse determinations should be upheld.

**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 AND KNOWLEDGE BASE
- 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)**