

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** JANUARY 19, 2010

**IRO CASE #:**

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

Medical necessity of proposed physical therapy: 97110, 97140, 97112, G0283 each for 3X 4 weeks

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- XX 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
722.93	97110, 97140, 97112, G0283		Prosp	12					Upheld

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

TDI-HWCN-Request for an IRO-57 pages

Respondent records- a total of 56 pages of records received to include but not limited to:  
TDI letter 12.29.09; Request for an IRO forms; records 9.24.09-12.3.09; preauthorization request;  
letters 11.25.09, 12.10.09; Dr. note 9.16.09; MRI L-spine 7.9.09; note, Dr 11.3.09; note Dr. for patient 12.2.09

Requestor records- a total of 19 pages of records received to include but not limited to: note 11.12.09-12.14.09; Dr. note 11.3.09; letters 7.7.09, 8.31.09, 11.25.09

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The records presented for review begin with an electrodiagnostic assessment noted a normal study. An MRI of the lumbar spine reports a 3mm disc lesion at L4-5 and a 6mm lesion at L5-S1 with degenerative facet and ligamentum flavum hypertrophy.

There is a request for an ADDITIONAL 12 session of physical therapy, manual therapy, neuromuscular reeducation and electric stimulation. This was non-certified and the reconsideration was also non-certified. The rationale noted that 18 sessions had been completed with no objective documentation of any improvement. A suggestion for a home-based, self-directed exercise program emphasizing overall conditioning and fitness (HEP) was made.

In the response to the non-certification, Dr. noted that 12 and not 18 sessions had been completed and that the therapy was for the thoracic spine and not the lumbar spine. The November 3 progress notes of Dr. indicate that the pain was in the low back and the "lumbar disc protrusions, non-compensable." It also appears that Dr. is relying upon the physical assessment of a chiropractor whose signature is illegible.

**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.**

**RATIONALE:**

As noted in the Division mandated Official Disability Guidelines physical therapy is warranted, however, only up to a certain number of sessions. Further, the exact lesion being addressed is not fully explained in the notes offered by the requesting provider, nor is the physical therapy assessment and determination of the utility of the treatments rendered. Therefore, based on the lack of specific competent, objective and independently confirmable medical evidence to support the contrary, there is no clear clinical indication for additional p/t in this case.

**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