

CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 Physical Therapy Visits between 6/14/2011 and 8/13/2011

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 15 years experience.

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

9/13/10: CT Cervical Spine Without Contrast. Impression: Severe localized degenerative changes at the C6-7 level. Multilevel cervical disk bulging, and small central protrusion at the C4-5 level; which can be better evaluated with MRI, if clinically indicated.

9/13/10: CT Brain Without Contrast. Impression: No acute intracranial pathology.

10/7/10: MRI Lumbar Spine. Impression: Negative study.

10/26/10: M.D., PM&R physician, evaluated the claimant. PE: No PE is provided. Impression: Acute cervical pain syndrome. Acute thoracic pain syndrome. Acute lumbar pain syndrome. Acute sacroiliac pain syndrome. Acute lumbar facet pain syndrome.

11/1/10-11/18/10: During this time frame the claimant underwent 8 PT sessions.

11/9/10: M.D., PM&R physician, re-evaluated the claimant. PE: No PE is provided. Work Status: He is currently working full time at Direct TV doing light-duty office work. Medications: Motrin and Lortab.

11/11/10: M.D., PM&R physician, re-evaluated the claimant. PE: No PE is provided. Medications: Motrin and Lortab.

11/18/10: M.D., PM&R physician, re-evaluated the claimant. PE: No PE is provided. Medications: Motrin and Lortab. Treatment Plan: Consultation with neurosurgeon, EMG/NCV studies, Continue PT, and Continue therapeutic laser treatment.

1/19/11: D.O. evaluated the claimant. EMG nerve testing showed no acute electromyographic changes. Medications: An occasional NSAID. PE: Moderate cervical tenderness. Trigger point tenderness throughout the left trapezius, interscapular, and rhomboid regions. Motor and sensory testing in the upper extremities unremarkable. Positive Spurling's test. Hoffman's test negative. Impression: Chronic neck pain syndrome associated with cervicogenic headache following traumatic MVA. Cervical facet syndrome with cervicogenic headache. Cervical disk disruption with radiculitis. Myofascial pain syndrome of the cervical, mid thoracic, and lumbar regions. Mild to moderate reactive depression and anxiety in a chronic pain state.

2/8/11: D.O. performed a Cervical ESI.

2/15/11: M.D. performed an IME on the claimant. PE: No atrophy of the upper extremities. Sensation is normal. DTRs are normal bilaterally. Assessment: Cervical strain and lumbar strain without evidence of radiculopathy.

3/22/11: D.O. re-evaluated the claimant. PE: No PE is provided. Medications: Amitriptyline 20 mg, Hydrocodone, and Vicodin.

4/19/11: M.D., a family medicine physician, performed a DDE on the claimant. Dr. Palmer placed the claimant not at MMI and recommended an ESI.

6/6/11: M.D. performed a UR on the claimant. Rational for Denial: The number of requested visits on top of the previous therapy sessions is in excess of the recommended number. The documents submitted do not provide the prerequisite exceptional factors that would conform to the guidelines.

6/21/11: M.D. performed an UR on the claimant. Rational for Denial: This claimant was certified with 9 physical therapy visits. However, there is no documentation of objective functional improvement with previous treatment and a statement identifying why a home exercise program would be insufficient.

PATIENT CLINICAL HISTORY:

The claimant was injured during a MVA.

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

Denial of additional therapy is upheld. Per ODG requested number of visits exceeds ODG recommended number of visits for various diagnoses. Furthermore, there is no documentation of functional improvement with previous physical therapy sessions.

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#), including assessment after a "six-visit clinical trial".

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

Lumbago; Backache, unspecified (ICD9 724.2; 724.5):

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Medical treatment: 10 visits over 8 weeks
Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks
Post-surgical treatment (arthroplasty): 26 visits over 16 weeks
Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks
Intervertebral disc disorder with myelopathy (ICD9 722.7)
Medical treatment: 10 visits over 8 weeks
Post-surgical treatment: 48 visits over 18 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
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)