

SENT VIA EMAIL OR FAX ON  
Dec/27/2010

## **P-IRO Inc.**

An Independent Review Organization  
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### **NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:**  
Dec/27/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Physical Therapy 3 X wk X 6 wks neck and back

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
Board Certified Orthopedic Surgeon

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Office Note, Dr.: 09/07/10, 09/20/10, 09/21/10 and 11/02/10  
MRI Report: 09/13/10 x 2  
Therapy Note: 09/27/10 and 11/01/1  
Notification of Determination: 11/09/10  
Reconsideration Letter: 11/11/10  
Reconsideration: 11/19/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female with a reported injury on xx/xx/xx when she was hit by soccer ball in the back and knocked down. She reported low back pain with numbness and tingling into the left foot; neck pain with numbness and tingling into the right hand; and headache, pain and spasm. Dynamic radiographs of the lumbar and cervical spine on 09/07/10 showed L5-S1 functional spinal unit collapse with facet subluxation, foraminal stenosis and spondylosis; L4-5 minimal spondylosis; functional spinal unit collapse near bone on bone in axial plane at C5-

6 and C6-7; and C3-4 retrolisthesis in extension, spondylosis and stenosis. Physical examination demonstrated lumbar spasm, positive spring test at L5-S1, positive extension lag, sacroiliac tenderness, decreased left ankle reflex, absent posterior tibial reflex bilaterally, paresthesia in the L5-S1 distribution on the left, positive cervical compression test, positive shoulder abduction on the right, paresthesia in the C6 and C7 distribution on the right, decreased biceps and triceps reflex on the right, negative Tinel's and negative Phalen's. The claimant was given a Medrol Dose Pack, pain medication and medication for muscle spasms. The claimant was to remain off work. Lumbar MRI evaluation performed on 09/13/10 showed mild lumbar rotoscoliosis without subluxation or retrolisthesis; moderate narrowing with decreased signal and spondylosis at T12-L1, L1-2 and L2-3; T12-L1 with 4.0 millimeter subligamentous disc protrusion that flattened the thecal sac; L1-2 with 3.0 millimeter disc bulge that flattened the thecal sac and mild bilateral foraminal narrowing; L2-3 with 4.0 millimeter disc bulge that flattened the thecal sac with mild bilateral foraminal encroachment; L3-4 with annular disc bulge without focal herniation and no foraminal narrowing; L4-5 with 4.0 millimeter subligamentous disc protrusion with radial tear in the outer annulus and flattening of the thecal sac, bilateral facet arthrosis with moderate narrowing of the right and mild narrowing of the left foramen; and L5-S1 with no focal herniation or foraminal narrowing. Cervical spine MRI evaluation also performed on 09/13/10 was limited due to severe claustrophobic anxiety and showed C3-4 severe disc space narrowing with 3.0 millimeter annular disc bulge, prominent hypertrophy of the uncovertebral joint and severe narrowing of the left foramen; C4-5 annular disc bulge that flattened the thecal sac; C5-6 with moderate narrowing and 3.0 millimeter disc bulge with spondylosis, flattening of the thecal sac and narrowing of the right foramen; C6-7 annular disc bulge with flattening of the thecal sac but without focal disc herniation or foraminal narrowing; and subluxation of C7 on T1 with 5.0 millimeter subligamentous disc extrusion that effaced the thecal sac and flattened the cord, facet joint arthrosis and mild canal stenosis with severe bilateral foraminal narrowing. Dr. saw the claimant on 09/21/10 and reviewed the MRI findings. The claimant had ongoing complaints of pain and the physical examination was unchanged. The claimant was diagnosed with traumatic cervical and lumbar disc herniation with primarily right upper extremity radiculopathy and left lower extremity radiculopathy. Notation was made that the claimant had had good results with prior physical therapy and that was recommended again. The claimant attended 15 physical therapy sessions from 09/27/10 and 11/01/10 with some improvement in strength, motion, endurance and ability to transfer noted. The claimant continued to have a "labored" gait and required use of a cane or holding onto furniture. Recommendation was made to continue physical therapy for an additional 18 sessions.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The evidence based ODG Guidelines recommend services such as physical therapy for soft tissue injuries to the neck and back. In general the recommendations allow for fading of treatment frequency, accumulating up to ten visits over eight weeks. In general this should provide adequate resolution of symptoms for the overwhelming majority of individuals recognizing that there are some exceptions.

The records do not make a compelling case that the claimant's case in its self be considered exceptional. While she has imaging studies, which show varying degrees of degenerative change, they appear to be largely pre-existing without acute pathology. She appears to have been given ample opportunity to attend physical therapy and in fact has exceeded the normal number of visits recommended in the ODG Guidelines (fifteen sessions). While one cannot deny that part of the records document that the claimant continues to have ongoing symptomology and may in fact require further treatment for her ongoing symptoms it is unclear as to why she would not be a reasonable candidate to transition to a home exercise program after completing a number of therapy sessions to date as recommended by the ODG. As such based on the careful review of the records provided, this reviewer would uphold the previous denial of the request for additional physical therapy as there are no compelling indications in this particular case that would suggest why she could not be transitioned into a home exercise program as recommended by the ODG.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates; Low Back- Physical Therapy and Neck- Physical Therapy  
Lumbar: Allow for fading of trmt frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT  
Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):  
Lumbar  
Medical treatment: 10 visits over 8 weeks  
Post-injection treatment: 1-2 visits over 1 week  
Intervertebral disc disorder with myelopathy (ICD9 722.7)  
Medical treatment: 10 visits over 8 weeks  
Lumbar sprains and strains (ICD9 847.2):  
10 visits over 8 weeks  
Cervical: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT.  
Displacement of cervical intervertebral disc (ICD9 722.0):  
Medical treatment: 10 visits over 8 weeks  
Post-injection treatment: 1-2 visits over 1 week  
Degeneration of cervical intervertebral disc (ICD9 722.4):  
10-12 visits over 8 weeks

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

ACOEM-AMERICA 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)