

Notice of Independent Review Decision

January 25, 2011  
January 28, 2011 Amended Date

**DATE OF REVIEW:** 01/25/2011

**IRO CASE #:**

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

12 Physical Therapy Treatment Sessions

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

**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.

The apparent services that have been denied and for which the IRO request has been generated are indicated to be prospective preauthorization of 12 physical therapy treatment. Clinical decision based on my review of the medical records identified above and noting, in particular, there is no narrative or other information from the requesting doctor to explain a necessity for additional

physical therapy that would extend past the ODG criteria, the original denial for preauthorization is recommended to be upheld.

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

Records Received: 18 page fax 01/05/11 Texas Department of Insurance IRO request, 29 page fax 01/10/11 URA response to disputed services including administrative and medical records.

1. Insurance.
  - Preauthorization denial, 11/23/10.
  - Reconsideration denial, 12/06/10.
2. Physical therapy treatment reports from Sports Medicine and Rehabilitation during October 2010.
3. Report of surgery from Medical Center 06/18/10 reporting ACDF C5-6/C6-7.
4. Medical records postsurgical follow-up from M.D., for dates of service 07/07, 08/31, and 10/13/10.

Report of designated doctor examination from Evaluation Center, 11/05/10, by M.D., indicating that the patient reached maximum medical improvement 01/02/08 with an impairment of 0% based on the *AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition*, utilizing the DRE methodology.

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

The medical records concerning this individual indicate that she tripped over a computer cord that was on the floor at her place of employment and fell forward, landing on outstretched arms. She underwent significant history for a prolonged period of time, including medication and physical therapy and ultimately with confirmation diagnosis of abnormal cervical disk disease, surgery. Surgery was done 06/18/10. The surgeon was M.D.

The postoperative diagnoses included the following:

1. Neck pain with right upper extremity radiculopathy.
2. Cervical spondylosis C5-6, C6-7.
3. Herniated nucleus pulposus, right, C5-6.

The operative procedure performed was indicated to have been:

1. Anterior cervical discectomy with decompression, C5-6/C6-7.
2. Arthrodesis with anterior interbody fusion, C5-6/C6-7.

3. Spinal instrumentation, C5-C7 using Synthes Vectra 30-mm plate and six 16 x 4.0-mm screws. Implants using PEEK 6-mm, 7-mm, and an allograft using chronOS.

The patient underwent postsurgery follow-up with Dr. and more recently underwent physical therapy at in October and apparently November 2010. According to the records, she received a total of some 18 postsurgical physical therapy treatments.

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

The apparent services that have been denied and for which the IRO request has been generated are indicated to be prospective preauthorization of 12 physical therapy treatment sessions and electromyography of the upper extremity. Clinical decision based on my review of the medical records identified above and noting, in particular, there is no narrative or other information from the requesting doctor to explain a necessity for additional physical therapy that would extend past the ODG criteria, the original denial for preauthorization is recommended to be upheld

**Physical Therapy (P.T.):** Recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider to avoid debilitation and further restriction of motion ([Rosenfeld, 2000](#)) ([Bigos, 1999](#)). For mechanical disorders of the neck, therapeutic exercises have demonstrated clinically significant benefits in terms of pain, functional restoration, and patient global assessment scales ([Philadelphia, 2001](#)) ([Colorado, 2001](#)) ([Kjellman, 1999](#)) ([Seferiadis, 2004](#)). Physical therapy seems to be more effective than general practitioner care on cervical range of motion at short-term follow-up ([Scholten-Peeters, 2006](#)). In a recent high quality study, mobilization appears to be one of the most effective non-invasive interventions for the treatment of both pain and cervical range of motion in the acutely injured WAD patient ([Conlini, 2005](#)). A recent high quality study found little difference among conservative whiplash therapies, with some advantage to an active mobilization program with physical therapy twice weekly for three weeks ([Kongsted, 2007](#)). See also specific physical therapy modalities as well as "Exercise."

**ODG Physical Therapy Guidelines –**

Allow for fading of treatment frequency (from up to three visits per week to one or less) plus active self-directed home P.T. 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."

Cervicalgia (neck pain); cervical spondylosis (ICD9 723.1; 721.0):

9 visits over 8 weeks

Sprains and strains of neck (ICD9 847.0):

10 visits over 8 weeks

Displacement of cervical intervertebral disk (ICD9 722.0):

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 (fusion, after graft maturity):

24 visits over 16 weeks

Degeneration of cervical intervertebral disk (ICD9 722.4):

10-12 visits over 8 weeks

See 722.0 for post-surgical visits

Brachia neuritis or radiculitis NOS (ICD9 723.4):

12 visits over 10 weeks

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See 722.0 for post-surgical visits  
Post laminectomy syndrome (ICD9 722.8):  
10 visits over 6 weeks  
Fracture of vertebral column without spinal cord injury (ICD9 805):  
Medical treatment: 8 visits over 10 weeks  
Post-surgical treatment: 48 visits over 18 weeks  
Work conditioning (See also [Procedure Summary](#) entry):  
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)

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- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME  
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

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