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Notice of Independent Review Decision

DATE OF REVIEW: 05/08/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Nine physical therapy visits for the cervical/lumbar spines to include CPT codes 97110, 97112, and 97140

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal 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.

Nine physical therapy visits for the cervical/lumbar spines to include CPT codes 97110, 97112, and 97140 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with D.O. dated 09/02/10, 09/23/10, 10/12/10, 10/20/10, 11/02/10, 11/30/10, 01/11/11, 02/22/11, 04/05/11, 05/03/11, 05/31/11, 06/24/11, 07/12/11, 08/09/11, 08/16/11, and 02/06/12

DWC-73 forms dated 09/02/10, 09/23/10, 10/12/10, 10/20/10, 11/02/10, 11/30/10, 01/11/11, 02/22/11, 04/05/11, 05/03/11, 05/31/11, 06/24/11, 07/12/11, 07/18/11, and 08/09/11

Evaluations with D.C. dated 09/14/10

Physical therapy notes dated 09/23/10, 09/24/10, 09/27/10, 09/29/10, 10/01/10, 10/04/10, 10/05/10, 10/08/10, 10/11/10, 10/13/10, 10/15/10, 10/18/10, and 10/20/10

X-rays of the right hand, cervical spine, thoracic spine, and the lumbar spine dated 09/29/10 and interpreted by M.D.

CT scan of the lumbar spine dated 10/18/10

Functional Capacity Evaluation (FCE) dated 10/28/10 with F.N.P.

Lumbar MRI dated 11/08/10 and interpreted by Dr.

Evaluation with M.D. dated 01/06/11

Evaluation with M.D. dated 01/31/11

EMG/NCV study dated 01/31/11 and interpreted by M.D.

Designated Doctor Evaluation dated 07/08/11 with M.D.

DWC-69 forms dated 07/08/11, 08/15/11, and 11/03/11

Impairment rating evaluation dated 08/15/11 from D.C.

Amended Report of MMI/IR dated 11/03/11 from Dr.

X-rays of lumbar spine dated 02/06/12 and interpreted by M.D.

Reports from M.D. dated 02/16/12, 02/27/12, 03/06/12, 03/12/12, 03/14/12, 03/19/12, and 03/21/12

Request for physical therapy from Dr. dated 03/02/12

Notifications of Determination from dated 03/07/12 and 04/04/12

Undated Certificate of Medical Necessity from Dr.

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 09/02/10, Dr. diagnosed the patient with a cervical strain, cervical spasm, low back pain, and headaches following an MVA. Darvocet, Soma, Naproxen, and therapy were prescribed. The patient attended therapy on 09/23/10, 09/24/10, 09/27/10, 09/29/10, 10/01/10, 10/04/10, 10/05/10, 10/08/10, 10/11/10, 10/13/10, 10/15/10, 10/18/10, and 10/20/10. X-rays of the right hand on 09/29/10 revealed mild carpal arthritic changes peripherally. The cervical x-

rays revealed minimal degenerative disc disease and no evidence of fracture or subluxation. Thoracic films revealed moderate multilevel degenerative disc disease. The lumbar spine showed moderate degenerative disc disease and suspected L5 spondylosis. On 10/12/10, Dr. continued Soma, Naproxen, and Darvocet. A CT scan of the lumbar spine dated 10/18/10 revealed mild multilevel degenerative disc disease and moderate right sided degenerative facet arthritis at L4-L5. There was an L5-S1 disc bulge and facet arthritis that produced moderate right neuroforaminal stenosis and mild right sided changes of degenerative sacroiliitis were noted. There were also findings consistent with autosomal dominant polycystic kidney disease. On 10/20/10, Dr. continued his medications and recommended an FCE, which was performed on 10/28/10. It revealed he was functioning in the medium physical demand level and his previous employment required the heavy physical demand level. He was being referred for a mental health evaluation and a work hardening program was recommended. Dr. prescribed Tramadol and advised the patient to continue the Medrol Dosepak. A lumbar MRI was recommended. A lumbar and right thigh MRI dated 11/08/10 revealed mild degenerative disc disease and mild degenerative facet arthritis and no evidence of disc displacement, spinal stenosis, or neuroforaminal stenosis. The right thigh MRI revealed no pelvic or thigh lesion, but there was an abnormal right lateral femoral condyle. Dr. examined the patient on 01/06/11. He felt the patient was not a surgical candidate for his spine. Light duty and work conditioning was recommended. Dr. Sued examined the patient on 01/31/11 and recommended an EMG/NCV study and Tramadol, Naproxen, and off duty were continued. An adductor tendon block was also recommended. An EMG/NCV study was obtained on 01/31/11 and were normal. However, it was noted the absence of sensory response might be consistent with a sensory neuropathy as seen with toxic, metabolic, infectious, or inflammatory symptoms. Dr. reexamined the patient on 02/22/11 and prescribed Percocet and Soma and Naproxen were continued. It was noted a second EMG/NCV study was pending. Dr. noted on 05/31/11 that Dr. was recommended an ESI. On 07/08/11, Dr. placed the patient at MMI with a 1% whole person impairment rating. Dr. placed the patient at MMI on 08/15/11 with a 6% whole person impairment rating. Dr. provided an amended report on 11/03/11 regarding a new nerve study he received that changed the patient's whole person impairment rating to 11%. Dr. examined the patient on 02/06/12. He had mild cervical pain with pain to the right hand with numbness. Range of motion was decreased in the back due to spasms. Ketorolato was continued and x-rays of the lumbar spine were recommended, which were performed on

02/06/12 and revealed anterior marginal osteophyte changes associated with vacuum disc phenomenon at L2-L3 and L3-L4. There was no evidence of spondylosis or spondylolisthesis. On 02/27/12, Dr. diagnosed the patient with a lumbosacral sprain, sciatica, lumbosacral neuritis, mononeuritis of the lower limb, pain in limb, lumbago, and spasm of muscle. A lumbar MRI and 12 sessions of physical therapy were recommended. On 03/06/12, Dr. refilled Ketorolato and started Ultram. A lumbar MRI was again recommended, as well as a physical medicine evaluation. On 03/07/12, M.D., on behalf of Coventry, denied the requested 12 sessions of physical therapy for the cervical/lumbar spine. Dr. noted on 03/19/12 the patient had severe pain in his neck and low back. He received myofascial therapy, stretching and therapeutic exercises, as well as electrical stimulation. Dr. continued Ultram and Ketorolato on 03/21/12 and recommended a restorative program. On 04/04/12, on behalf of, provided an adverse determination for the requested nine visits of therapy for the cervical/lumbar spine to include CPT codes 97110, 97140, and 97112.

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

The mechanism of injury would have, at most, produced a sprain/strain. There is no evidence of significant or severe injury based on the documentation provided at this time. There is manifestation of pain behavior. The patient has received the appropriate therapy for the cervical and lumbar spines, according to the recommendations of the ODG. There are no specific reasons or objective documentation as to why the claimant could not further strengthen his spine in a home exercise program. Therefore, the requested nine sessions of physical therapy for the cervical/lumbar spines to include CPT codes 97110, 97112, and 97140 is not reasonable and necessary and the previous adverse determinations should be upheld at this time.

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)**