

# Parker Healthcare Management Organization, Inc.

3719 N. Beltline Rd Irving, TX 75038  
972.906.0603 972.906.0615 (fax)  
IRO Cert#5301

**DATE OF REVIEW:** MAY 21, 2016

**IRO CASE #:**

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

Medical necessity for physical therapy 2 X week X 8 weeks, neck/pain/myofascial pain

## **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:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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

**CLINICAL HISTORY:** The claimant is a female who was injured on XX/XX/XX, in a fall backwards, striking furniture. The claimant was diagnosed with a lumbar strain. A physical therapy note from XX/XX/XX, documented the claimant was being treated for cervicgia. The claimant was unable to work secondary to dysfunction. The current pain was 8/10 on a visual analog scale. The claimant reported the pain affected ability to concentrate and was unable to perform work duties due to not being able to lift/carry and from the significant light sensitivity. The claimant had attended greater than 20 sessions of therapy for the low back pain and received a steroid injection on XX/XX/XX for the lumbar spine. The claimant had severe adverse reaction to the steroid injection and required a blood patch on XX/XX/XX. The claimant had been going through pain management. An MRI of the lumbar spine on XX/XX/XX, reported mild degenerative changes at L3-L4 and L4-L5 with an annular disc bulge at L4-L5 and facet joint hypertrophy. An MRI of the brain on the same date was normal. The physical examination demonstrated motor strength was 4-/5 to 5-/5 in the left upper extremity and 3+/5 to 5-/5 in the right upper extremity. Range of motion of the cervical spine was 40% of normal in extension, 35% in flexion, 35% in rotation to the left, 28% in rotation to the right, 15% in side bending to the left, and 20% in side bending to the right. The records noted the claimant required skilled therapy to address problems identified and achieve individual goals. The recommendation was for two visits a week for eight weeks. The clinical note of XX/XX/XX, noted the claimant's problem was unchanged. The claimant had undergone a rating for maximum medical improvement and impairment and found to be at clinical maximum medical improvement on XX/XX/XX, with an impairment rating of 5%. The claimant had undergone three maximum medical improvement and DREs and would be released from worker's compensation care on that date, and would need to follow-up with primary care doctor and specialist for further evaluation and treatment of low back pain and headaches. The request was previously

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noncertified on XX/XX/XX. A peer- to-peer was attempted, but not established. The documentation for past treatment included treatment in formal physical therapy services. The records available did not document the presence of any new changes in neurological examination compared to previous. The above noted reference would support an except for the ability to perform a proper non-supervised rehabilitation regimen for the described medical situation when individual is this far removed from the date of injury and when past treatment has included access to treatment in the form of supervised rehabilitation services. Consequently, presently, medical necessity for this specific request was not established for the described medical situation.

## **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, nine visits of physical therapy for cervicgia. The claimant has undergone at least 20 physical therapy visits to date. There are no current clinical notes from the treating provider, documenting the medically necessity, including extenuating circumstances, to support why the claimant needs to continue in a structured physical therapy program versus a home program. The clinical note from XX/XX/XX, reported the claimant had already been evaluated for maximum medical improvement and impairment rating and found to be at maximum medical improvement on XX/XX/XX, with an impairment rating of 5%. The claimant was released from Worker's Compensation care and instructed to follow with primary doctor and specialist for further evaluation and treatment of the low back pain and headache. There is no indication the claimant sustained any benefit from previous therapy provided. The request for physical therapy two times a week, for eight weeks is not supported.

Official Disability Guidelines

Neck & Upper Back (updated XX/XX/XX)

Cervicgia (neck pain); Cervical spondylosis:

9 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 KNOWLEDGBASE
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)