

**NOTICE OF REVISED INDEPENDENT REVIEW DECISION**

**(See bold type)  
December 12, 2007**

**DATE OF REVIEW:** 12/07/07  
**DATE OF REVISION:** 12/12/07

**IRO CASE #:**

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

Physical therapy 2 X weekly X 5 weeks

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Neurologist and Fellowship-trained Pain Specialist, Board Certified in Neurology and Pain Medicine

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be :

Upheld (Agree)

**Overturned (Disagree)**

Partially Overturned (Agree in part/Disagree in part)

**Physical therapy 2 X week X 5 weeks (97010, 97014, 97110, 97140, 97002) is medically necessary in this case.**

**INFORMATION PROVIDED FOR REVIEW:**

1. TDI Case Assignment
2. URA letters of denial and ODG utilized in the denial
3. Treatment notes dated 10/19/06 through 11/02/06
4. Pain Management treatment notes dated 12/11/06 through 09/20/07 (7 visits) and letter of Medical Necessity dated 10/25/07
5. Physical therapy initial evaluation dated 09/24/07 and preauthorization requests dated 09/26/07 and 10/26/07
6. Operative reports dated 06/08/07 and 08/24/07

**INJURED EMPLOYEE CLINICAL HISTORY:**

This claimant sustained a work-related injury on xx/xx/xx while lifting a 45-gallon trashcan, developing immediate onset of low back pain. Treatment has included physical therapy and eventually treatment for a right-sided lumbar facet syndrome with radiofrequency denervation procedure. This resulted in significant relief of his ongoing back pain "by at least 75%." Request for additional physical therapy now after the procedure has been denied.

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

I am in agreement with the treating physician that an additional course of physical therapy is necessary now not only to maintain the improvement he has seen, but to make further progression in his pain condition. The radiofrequency procedure is not expected to result in "permanent" improvement, and its effect can wear off after several months.

Therefore, it is very important for the patient to proceed with physical therapy to continue to improve the underlying condition of the facet joints and the lumbar spine so that joints will be in a less painful state by the time the effects of the radiofrequency procedure wear off. Therefore, I believe that it is reasonable and medically necessary for this claimant to proceed with additional physical therapy as ordered, 2 X weekly for 5 weeks.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)