



DATE OF REVIEW: 04/29/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy 3 times per week times 6 weeks.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

Duly licensed physician in the State of Texas, D.O., fellowship-trained in Pain Management, Board Certified in Anesthesiology and Pain Medicine, DWC Approved Doctor List Level II, practicing Pain Management for almost 20 years

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

Medical records from treating doctor from 01/25/07 through 03/09/07

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This claimant was injured on. On the claimant was seen in follow up by the treating doctor (TD) who documented the claimant’s ongoing complaint of back pain radiating into the side (side not specified). Physical exam documented only tenderness at the lumbosacral segment with no neurologic deficits. The TD released the claimant to light duty work and ordered physical therapy 3 times a week for a month.

The claimant returned to the TD complaining of worse pain, now radiating down the right thigh into the leg. Physical examination documented tenderness over the iliac crest and right sacroiliac joint with positive straight leg raising on the right. Neurologically the claimant was said to be intact. TD then apparently ordered a lumbar MRI scan. Initial review of the request for physical therapy was performed by an orthopedic surgeon who recommended against authorization of additional physical therapy, stating the claimant had had ten (10) visits of physical therapy to that point and, according to the therapist, had been educated in therapeutic exercise.

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TD followed up with the claimant on, now documenting primarily lumbar pain only. No physical exam was documented. TD did, however, note that the claimant was demonstrating pain “in excess of what I expect at this point in time,” recommending referral to a pain specialist. A second review of the request for physical therapy was completed on 03/01/07 by a different orthopedic surgeon who concurred with the recommendation for non-authorization. That physician noted EMG results of no nerve root radiculopathy and MRI scan results of an alleged small right L5/S1 herniation. TD’s physician assistant followed up with the claimant on 03/09/07, one day after having had an epidural steroid injection. The claimant now stated his pain was no worse than 2/10 to 3/10. Physical exam documented negative straight leg raise test sitting and standing, normal reflexes, normal strength, and entirely normal neurologic exam. The physician assistant recommended further epidural steroid injections and continued light duty work.

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

This claimant has completed 10 sessions of physical therapy for his work injury. According to the information provided for my review, the physical therapist felt that the claimant had progressed sufficiently to be discharged to a home exercise program. Therefore, in that regard there would be no medical reason or necessity for further supervised physical therapy as requested. Additionally, ODG Guidelines would not support such an extension of physical therapy. Additionally, according to the last progress note from the TD’s physician assistant, the claimant now had minimal pain and an entirely normal physical exam. He was also to continue in light duty work. Therefore, there is no medical reason or necessity for the claimant to require further supervised physical therapy with such a minimal pain level and no physical exam findings. Therefore, for all the reasons cited above, there is no medical reason or necessity for the requested extension of physical therapy. The adverse determination, therefore, should be upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).

_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)