



Notice of Independent Review Decision

DATE OF REVIEW: 10/26/07

AMENDED DATE: 10/31/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical necessity for the preciously denied physical therapy for the lower back.

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

Texas Licensed Chiropractor.

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)

The previously denied request for physical therapy for the lower back.

Injury Date	Claim #	Review Type	Begin Date	End Date	ICD9/DSM V	HCPCS/DC	Billing Modifiers	Service Units	Amount Billed	Upheld/Overtur ned
		Prosp			723.4	97110		3		Upheld
		Prosp			723.4	97112		1		Upheld
		Prosp			723.4	97140		1		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice of Assignment of Independent Review Organization dated 10/15/07.
- Notice to CompPartners, Inc. of Case Assignment dated 10/15/07.

- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/12/07.**
- **Peer Review Report dated 10/9/07, 10/2/07, 9/28/07, 9/27/07, 9/24/07, 7/25/07, 7/17/07.**
- **Determination Notification Letter (unspecified date).**
- **Progress Notes dated 7/19/07, 7/9/07.**
- **Company Request for Independent Review Organization dated 10/11/07.**
- **Request for a Review by an Independent Review Organization dated 10/10/06.**
- **Pre-Authorization Determination Report dated 10/8/07, 9/26/07.**
- **Request for Pre-Authorization dated 10/1/07, 9/24/07.**
- **Fax Cover Sheet/Authorization Request dated 9/24/07.**
- **Rehabilitation Request Form dated 10/4/07.**
- **Physical Therapy Referral Form dated 9/21/07.**
- **Operative Report dated 9/14/07.**
- **Review/Opinion Report/Letter of Evaluation of Permanent Impairment dated 7/6/07.**
- **Re-Evaluation Report dated 9/6/07, 8/16/07, 7/9/07.**
- **Daily Progress Notes dated 7/3/07, 6/29/07, 6/27/07, 6/25/07, 6/21/07, 6/19/07.**
- **Personal Program Stretch Exercise Instructions 6/19/07.**
- **Assignment of Benefits/Assignment of Interest in Third Party Claim dated 12/6/06.**

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: xx years
Gender: Female
Date of Injury: xx/xx/xx
Mechanism of Injury: Tripped over 3 boxes on the floor.

Diagnosis: Lumbar Disc Displacement; Brachial Neuritis NOS; Sprain Lumbar Region.

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

This is xx year old female who sustained a work related injury on xx/xx/xx when she was working for xxxx Hospital in the medical records department and tripped over three boxes which were on the floor, causing her to fall sideways with her back twisted on the floor. The provided diagnoses include 722.10-lumbar disc displacement without myelopathy, lumbar sprain, lumbar neuritis, and brachial neuritis. The claimant has received an undetermined total amount of physical therapy and chiropractic treatments, as well as at least two cervical epidural steroid injections (ESI) back on 5/31/07, and one on 7/5/07. She had a lumbar ESI procedure on 9/14/07 by MD. The nurse case notes indicated that the request for physical therapy was noted on the 9/21/07 prescription for 12 sessions of physical therapy for 3 x 4 weeks, and that according to the pre-authorization request it is for 6 sessions of physical therapy at 3 x 2 weeks. The preauthorization summary, dated 9/27/07, also indicated that the claimant had returned to work without restrictions and was terminated. The notes further indicated that the

claimant was being referred for a chronic pain program, which is currently pending. A review was performed by DC on 10/8/07, which indicated a denial for post lumbar ESI physical therapy. Dr. indicated that there were no new clinical records provided from Dr. DC or a rebuttal to the rationale for the initial denial based on 9/26/07. There is a 7/6/07 report from MD, who felt that the claimant's maximum medical improvement (MMI) date should be 3/5/07, since the primary treating doctor indicated that date previously, and that the designated doctor, Dr., MD, had made an error in the determination of the whole person impairment rating of 15%. The documentation received for this review indicated that the claimant had received adequate physical therapy over 8 months of the injury and had received at least 6 recent formal physical therapy sessions post the cervical spine ESI procedure. The most recent examination findings were noted on a 9/6/07 report from Dr. DC indicating continued chief complaint of cervical pain with radicular symptom into the left upper extremity and lower back pain with radicular symptom into the bilateral lower extremities. The objective exam revealed positive cervical compression test bilaterally, shoulder depression test on the left side, straight leg raising (SLR) was negative and positive Kemp's test on the right side. The Patrick-Fabere's test and Yeoman test were positive for sacroiliac (SI) joint pain. She continued to have anxiety issues. There were no documented clinical physical findings submitted in this date reevaluation indicating actual degrees of ranges of motion, no mention of neurological deficits and no mention of pain scale ratings or the claimant's inability to perform home exercises post lumbar ESI after receiving at least 6 prior post cervical ESI visits and an undetermined amount of physical therapy since her injury date. The current request is to determine the dispute resolution for previously denied physical therapy post lumbar ESI for 3 x 2 weeks. Reference is made to the Official Disability Guidelines, Treatment index, 5th edition, web based version regarding lumbar spine and lumbar ESI post physoc; therapy recommendations. The reference indicates that "As noted above, injections are recommended if they can facilitate a return to functionality (via activity & exercise). If post-injection physical therapy visits are required for instruction in these active self-performed exercise programs, these visits should be included within the overall recommendations under Physical therapy, or at least not require more than 2 additional visits to reinforce the home exercise program". Therefore, it is this reviewer's opinion that given the claimant has received post ESI cervical physical therapy of 6 sessions and an undetermined total amount of physical therapy instruction over the course of care this request would not be medically necessary and the claimant should be able to perform home exercises by this timeframe since there is no mention that she is not capable of home exercises. The determination is to uphold the previous denial.

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.
The ODG, Treatment index, 5th edition, web based version regarding lumbar spine, lumbar ESI procedures and post ESI physical therapy recommendations. http://www.odg-twc.com/odgtwc/low_back.htm#Epiduralsteroidinjections
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHRIOPRACTIC QUALITY ASSURANCE AND 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee’s employer, the injured employee’s insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.
