

Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 817-549-0311

IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW: 10/24/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3 times a week for 3 weeks, 97039

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

Reviewer is Board Certified in Family Practice and has an Certificate of Added Qualification in Sports 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

No ODG Guidelines

Prior utilization reviews

Clinical notes from Dr. dated 2/20/07, 2/27/07 and Dr. dated 6/14/07, 7/5/07, 7/12/07, 8/16/07,, 8/30/07, 9/13/07, 9/27/07,

MRI report (LS Spine) 7/10/07

Physical Therapy Reports (MPT) dated 6/19/07, 6/21/07, 6/25/07, 6/27/07, 6/28/07, 7/3/07, 7/5/07, 7/9/07, 7/10/07

Clinical notes from Chiropractor dated 7/24/07, 7/25/07, 8/8/07, 8/9/07, 8/13/07, 8/15/07, 8/16/07, 8/20/07, 8/21/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee reported the onset of acute low back pain as a result of lifting an object at work. He did have a prior history of low back pain and surgery on his back, although details of the history were not available to reviewer.

Patient's pain was localized to the lower back; he was treated with antiinflammatories and muscle relaxants. X ray indicated lumbar spasm and degenerative disc disease of the spine. On the second visit the patient was given some home exercises. By weeks post injury the pain was reportedly better and the patient was returned to full work activities. Patient returned months later again complaining of low back pain. No new injury was described. Patient was again treated with antiinflammatories and muscle relaxants and work was modified. Physical Therapy was initially prescribed at this time. When patient returned on 7/5/07, he still had low back pain. A Medrol dose pack was prescribed and an MRI ordered. The MRI showed evidence of degenerative disc disease with multiple levels of disc bulging. The disc bulging was causing some foraminal narrowing and at L2/3 showed some central canal narrowing. There was evidence of a hemilaminectomy at L5-S1. At this time, traction was added to the Physical Therapy prescription. From until the time of the MRI on 7/5/07, the patient had physical therapy visits with exercise, soft tissue mobilization, electrical stimulation, heat, ice. Home exercises were given as well. There were 2 additional visits after the MRI which included the same treatment. There was no note of traction on the notes. They did note that patient's pain and mobility were improving. On 7/24/07, the patient started seeing a chiropractor. Patient saw the chiropractor 9 times from 7/24-8/20/07. During these sessions he received muscle therapy, heat, electrical stimulation, ultrasound, and "other therapeutic procedure". It is not apparent from the notes whether this "other" procedure was traction or something else.

In addition to the treatments, the chiropractor prescribed exercises for disc herniation and core strengthening. During these visits the patients varied between 6/10 on first visit to a 3-5/10 on all other visits. Rest pain improved but pain with activity had not. On 8/16/07, patient returned to the primary care doctor and said pain had improved with traction (number of treatments is not indicated). The patient did report a 30-40% improvement with physical therapy. He reported getting worse a few weeks after stopping PT but it is not noted whether he was continuing the home exercise program.

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

This patient has the diagnosis of chronic lumbar pain secondary to degenerative disc disease with foraminal and central canal narrowing. ODG guidelines support the use of Physical Therapy for 10 sessions over 5 weeks for intervertebral disc disorders. This patient has received Physical therapy and adjunct modalities by a physical therapist for 9 visits and by a chiropractor for an additional 9 visits. These visits occurred over a period of 9 weeks. In addition to

this, the patient was doing home exercises. Based on the guidelines and supporting literature, there is no added benefit to a continued monitored physical therapy program. With a history of chronic low back pain, DJD and prior surgery, this patient should be continuing on a home maintenance back/ core exercise program for his lifetime.

With respect to the specific request of traction, the patient had 11 visits after the time at which it was ordered. It is unclear how many traction treatments the patient received in those 11 visits. The patient attributes his improving to the traction but with the prolonged length of time the patient received physical therapy and modalities it would be hard to say that it was the traction that helped. The ODG guidelines and studies do not support the use of power traction for the treatment of low back pain. There is some evidence for the use of home based traction but this has not been proven by studies.

The reviewer agrees with the previous determination. Additional physical therapy visits and continued office based traction are not medically necessary in this patient.

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
- 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)