

**Notice of Independent Review Decision**

**Revised Notice**  
**Corrected *Review Outcome* on page 4**  
**Corrected *Analysis and Explanation of the Decision* on page 5**

**DATE OF REVIEW:** 04-14-08

**IRO CASE #:**

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

Physical Therapy

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

Certified by the American Board of Anesthesiology  
Anesthesiology - General  
Pain 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)

Injury Date	Claim Number	Review Type	ICD9/ DSMV	HCPCS/NDC	Overturn/ Upheld
		Prospective	722.2	97035 97110 97002 97014 97124	Upheld

**Notice of Independent Review Decision**  
**Page 2**

				97140 97530 97113	
--	--	--	--	-------------------------	--

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Non-Authorization Recommendation dated, 03-24-08 and 03-31-08  
Pre-Authorization Intake Form  
Physician Therapy Referral dated, 03-03-08  
MRI – lumbar spine dated, 11-20-07  
Physician Evaluation dated, 03-03-08  
Initial (Physical Therapy) Evaluation dated, 03-10-08  
Office note dated, 03-03-08  
Physician noted dated, 03-03-08  
Official Disability Guidelines (ODG)-cited TWC Lumbar PT guidelines but not provided

**PATIENT CLINICAL HISTORY:**

The patient was injured at which time he had “some physical therapy in the past with minimal lasting effect”. The patient continues to suffer from chronic low back pain and right lower extremity radicular symptoms from a “mild broad right central to right subarticular protrusion at L5-S1” with “mild right foraminal narrowing” per MRI. The patient’s physical examination is positive for pain with flexion and extension of the lumbar spine, tenderness to palpation through palpatory pressure along the low back paravertebral musculature, spinous process of L1 to L5 and some mild pain and spasms in the gluteal musculature and along the iliac crest. “Generally, the patient has some limitations in ROM, tightness of the trunk and LE musculature and limited function”. The treating physician has requested physical therapy 3X’s per week for 4 weeks for a total of 12 sessions, and the request has been non-authorized.

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

In consideration of the entire treatment plan proposed (12 physical therapy visits), the Reviewer supports the decision of non-authorization. According to ODG guidelines, a course of therapy of 10 or fewer physical therapy visits over 8 weeks would be considered medically necessary, however, per the ODG

**Notice of Independent Review Decision**  
**Page 3**

guidelines for intervertebral disc disorders without myelopathy (ICD9 722.2), 12 visits are not.

Physical therapy is the treatment of a disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, activities of daily living and alleviating pain. Although the record indicates that the patient has had "some" previous physical therapy, there is no documentation to the total number and duration of previous visits, nor the specific therapies that were provided. The ODG guidelines state "there is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employee with low back pain. The most effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle strengthening exercises seem to be the most effective types of exercises for treating chronic low back pain". ODG Physical Therapy Guidelines allow for "fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT". The guidelines also state "unless noted otherwise, the visits indicated are for outpatient physical therapy, and the physical therapist's judgment is always a consideration in the determination of the appropriate frequency and duration of treatment".

**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**

**Notice of Independent Review Decision**  
**Page 4**

- 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)**