



DATE OF REVIEW: 12/9/08

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for physical therapy.

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

Texas licensed Orthopedic Surgeon.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for physical therapy.

There were no guidelines provided by the URA Case Manager for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx Years Old
Gender:
Date of Injury: xx/xx/xx
Mechanism of Injury: Not provided for this review.

Diagnosis: Extruded disc, lumbosacral spine with myofascial syndrome and radiculopathy

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

This xx year old female reportedly sustained an injury to her low back on xx/xx/xx, but the mechanism of injury was not provided in the reviewed records. A diagnosis of extruded disc, lumbosacral spine with myofascial syndrome and radiculopathy was documented. On 11/6/08, Dr. documented subjective findings of continued pain and tenderness in the back with radiating pain down into the left leg. The objective findings included spasms, pain and tenderness in the back with limited flexibility, range of motion (ROM), strength, and power. Dr. documented findings from an undated MRI, which revealed a herniated disc, extrusion type, in the lumbosacral spine at L5-S1 pressing on the nerve root. Conservative care included physical therapy, Vicodin, Norco, and off work.

A physical therapy report, dated 11/9/08, revealed the claimant was first seen on 10/18/08 and was classified as lumbar derangement with symptoms peripheralizing down the left lower extremity into the left foot and was noted to have difficulty with all functional activities and transitional movements. The claimant reported improvement with the pain no longer peripheralizing into her left foot, but stopped in the mid gastroc region. She reported that extension based stretching was very helpful. The objective findings revealed a positive left straight leg raise (SLR) at 70 degrees, tenderness in the left side of the L5 segment over the paraspinals, 4/5 motor testing on the left and pain with all transitional movements. The claimant demonstrated moderate lumbar extension ROM loss in prone with one repetition, but displayed within functional limits with 10 repetitions. She was noted to be able to heel and toe walk, but had slight difficulty with heel walking secondary to reduced dorsiflexor strength on the left.

Documentation revealed the claimant had completed 7 of 12 approved sessions of physical therapy. Continued physical therapy was recommended to include mobilization, home program instruction, lumbar stabilization exercise and modality treatment. Dr. requested authorization for physical therapy directed to the back, 2 to 3 times a week for 4 weeks.

There does not appear to be ongoing medical necessity for further requested physical therapy.

This claimant had a 9/5/08 injury and had back and radicular leg complaints. Dr. 11/6/08 office visit documented an MRI describing a herniated disc at L5-S1. There were then further physical therapy records by documenting her complaints, findings, and treatment. However, there was no documentation of how she had progressively improved or worsened with the therapy provided.

The ODG document the use of physical therapy for 10 visits over eight weeks in patients without progressive neurologic loss, and it would seem, based on the review of this medical record, that those number of visits have already been completed.

Therefore, there is no medical indication for any further visits, more than 10 over eight weeks, based on review of this medical record, as the records do not document the claimant's clinical condition while in therapy or any specific reason she needs more therapy and/or cannot do be doing home exercises. Therefore, further physical therapy is not medically necessary.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
Official Disability Guidelines, Treatment in Worker's Comp 2008 Updates,
Low Back - Physical therapy (PT).
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC 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).