

# Clear Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

**DATE OF REVIEW:** JANUARY 24, 2008

**IRO CASE #:**

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

Medical necessity of physical therapy three times a week for four weeks for right lower back.

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

M.D., Board Certified 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)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Denial Letters, Review Med, 12/5/07, 12/11/07

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back

Office notes, Dr., 10/31/07, 11/21/07, 01/04/08

Physical therapy evaluation, 11/01/07

MRI lumbar spine, 11/01/07

Physical therapy notes, 11/13/07 -11/19/07, 11/21/07-12/04/07, 12/05/07, 12/17/07, 12/18/07- 12/19/07

Prescription for physical therapy, 11/21/07

Preauthorization work sheet, 12/05/07

Reconsideration, 12/11/07  
Preauthorization Request Form, 12/11/07  
Pre-authorization Worksheet, 11/06/07, 12/11/07  
Financial Policy Statement, 11/13/07  
Preauthorization Request Forms, 12/05/07, 12/11/07  
Notice of Preauthorization Request, 12/12/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a xx year-old female injured on xx/xx/xx. On a 10/31/07 visit with Dr. the claimant reported she had been coming off an elevator and injured her mid and low back when the person behind her fell and pushed her forward. She also reported pain radiating into the legs. On examination there was tenderness of the parathoracic and paralumbar muscles, tenderness of the iliac crest, spasm and restricted motion. Straight leg raise caused back pain. X-rays showed slight narrowing at L5-S1. Medications and an MRI were recommended. An 11/01/07 MRI of the lumbar spine showed L4-5 and L5-S1 disc dessication with minimal bulging at L4-5 and a right central protrusion at L5-S1 with no deformity of nerve roots. On the 11/21/07 visit she was doing better in therapy. She had a physical therapy evaluation and fourteen sessions of therapy. On 01/04/08 Dr. noted that the claimant had increasing pain and down the right leg and numbness. On examination straight leg raise was positive on the right and there was a positive sciatic stretch on the right. The impression was disc herniation and 4 more weeks of physical therapy were recommended.

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

It is not clear to this reviewer as to the medical necessity for further physical therapy three times a week for four weeks for this person's low back complaints. The record indicates that she was injured in xx/xx and since that time she has had what appear to be fourteen (14) visits of physical therapy. Initially the records of Dr. on 10/31/07 documented spasm but the more recent 01/04/08 record does not document any spasm or neurologic deficit. I do not see the medical necessity of physical therapy three times a week for four weeks for right lower back for a person who has not had a progressive loss of function or progressive neurologic deficit.

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back-Physical Therapy

**Lumbar sprains and strains (ICD9 847.2):**

10 visits over 8 weeks

**Intervertebral disc disorder with myelopathy (ICD9 722.7)**

Medical treatment: 10 visits over 8 weeks

**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)