



Notice of Independent Review Decision

DATE OF REVIEW: 6/25/08

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 Occupational Medicine Physician.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Fax Cover Sheet dated 6/17/08.
- Notice to Comppartners, inc. of Case Assignment dated 6/17/08.

- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 6/17/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/16/08.
- Request for a Review by an Independent Review Organization dated 6/16/08.
- Company Request for Independent Review Organization dated 6/16/08.
- Denial of Reconsideration of Pre-Authorization or Concurrent Review Request dated 6/16/08, 6/12/08.
- Denial of Pre-Authorization or Concurrent Review Request/ Physician Determination-Initial Report dated 6/11/08, 6/5/08.
- Pre-Authorization Request Form dated 6/9/08, 6/4/08.
- Medical Necessity Letter dated 6/3/08.
- Re-Evaluation Report dated 5/30/08.
- Evaluation Report dated 5/19/08, 4/3/08, 2/21/08, 2/13/08.
- Referral Form (unspecified date).
- Lumbar Spine MRI dated 3/21/08.
- Texas Workers' Compensation Work Status Report dated 3/13/08, 3/6/08, 2/21/08, 2/13/08, (unspecified date).
- Physical Therapy Progress Note dated 3/12/08, 3/10/08, 3/7/08, 3/5/08, 3/3/08, 2/28/08, 2/26/08.
- Initial Evaluation Report dated 2/20/08.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Not Provided

Diagnosis: Low back pain syndrome, lumbar radiculopathy, and lumbar disk herniation.

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

This patient is a male who was involved in a work related injury. Limited information about the original injury was provided for review, but the patient sustained a low back injury. The current diagnoses include low back pain syndrome, lumbar radiculopathy, and lumbar disc herniation. A request has been submitted for additional physical therapy to the lumbar spine area, 3 times a week for 4 weeks, for an additional 12 physical therapy sessions. The patient had previously completed 12 prior physical therapy sessions, as per the carrier notes. This request for additional physical therapy has been reviewed by two prior physician reviewers, who both made a non-certification assessment. There was a note from Dr. orthopedist, dated 5/19/08. Despite prior physical therapy, it was noted that the patient continued to suffer from ongoing low back pain, right

buttock pain and right lower extremity pain. He had a baseline complaint of 5 out of 10 pain intensity. On examination, the patient had a decrease to light touch and pinprick in the L4-5 distribution, with pain on lumbar range of motion (ROM). An MRI of the lumbar spine showed a right sided lateral disc protrusion at the L4-5 level. Given the patient's ongoing complaints of pain with radiculopathy, despite prior medications and physical therapy, Dr. was ordering a lumbar epidural steroid injection (ESI) be performed. Later, electrodiagnostic testing was done, which was negative and did not confirm the presence of any radiculopathy or neuropathic process. The patient was seen by a physical therapist on 5/30/08. It was noted that the patient had been given a TENS unit by Dr. which was helpful. The patient had some low back pain complaints, described as "discomfort," and it was noted that "he is feeling and receives relief with the stretching exercises which he does daily." Examination results on that date noted "mild pain and tenderness" in the low back, buttock, and L4-5 area, with a slight decrease in lumbar ROM. There was no focal neurological deficit identified. At this time, this reviewer fails to see an indication for additional formal lumbar spine physical therapy. The patient had completed 12 physical therapy sessions, with essentially equivocal results. The patient is on record, however, as noting that the independent stretching that he was doing via a home exercise program is helping him. Exam findings were unremarkable, with limited and somewhat varying presentation of neurological deficit. Given that the patient had completed 12 prior physical therapy sessions for his lumbar condition, and given his current clinical presentation, coupled with his self-described benefit from his home exercise program, this reviewer is unable to recommend further formal physical therapy at this time. The ODG Guidelines state, "Physical Therapy - Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8): Medical treatment: 10 visits over 8 weeks." Therefore, this reviewer recommends non-certification of additional physical therapy for the lumbar spine x 12 sessions.

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.
- AHCPH – 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.
ODG Treatment Web Based Guidelines, 6th Edition, 2008 Integrated
Treatment/Disability Duration Guidelines Low Back - Lumbar & Thoracic (Acute & Chronic)
- 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).