

**Notice of Independent Review Decision**

**DATE OF REVIEW:**            05-20-08

**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 Orthopedic Surgery

**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 #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Units of Service	Upheld/ Overturned
		Prospective	847.2 722.10 722.52 722.73 724.6	97110 97010 97035 97032	12	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letter dated 04-15-08 and 04-28-08

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Physical Therapy notes dated 03-13-08, 03-17-08, 03-19-08, 03-21-08, 03-24-08, 03-26-08, 03-31-08, 04-02-08, 04-04-08, 04-07-08, 04-09-08

MRI Lumbar Spine dated 03-11-08

Progress Notes dated 03-10-08, 03-14-08, 03-28-08

Progress notes dated 01-13-06, 02-09-06, 04-11-08

Pre-authorization Request and Reconsideration Request

Official Disability Guidelines (ODG): TWC Low Back-Physical therapy (PT)

**PATIENT CLINICAL HISTORY:**

The claimant sustained a lumbar spine injury. A MRI obtained on 03-11-08 showed disc desiccation at L2-L3 and L4-L5, a mild annular disc bulge at L2-L3 without herniation, and a small focal left paracentral disc bulge at the L4-L5 level. The progress note of 03-14-08 noted the MRI findings, that the claimant was continuing to have some low back pain with radicular pain in the left lower extremity, was starting with physical therapy, and was taking antiinflammatory and analgesic medications for the pain. Physical therapy was continued for a total of at least 10 sessions, noting an improved range of motion. A provider note of 04-11-08 notes the claimant has radicular symptoms, is continuing to make slow but steady progress with physical therapy, and the pain has improved enough so that the claimant could return to work. A diagnosis of muscle strain/sprain lumbar spine and lumbosacral degenerative disc disease was given at this visit.

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

According to the Reviewer, it is noted in the Division mandated Official Disability Guidelines that physical therapy is "Recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. 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."

However, it is also noted that "Lumbar sprains and strains (ICD-9 847.2): 10 visits over 8 weeks." In the opinion of the Reviewer and based on medical record documentation, given the amount of physical therapy already completed and noting the progress made in the first 11 sessions, there is no competent, objective, and independently confirmable medical evidence presented to support

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the medical necessity of an additional 12 sessions of physical therapy for the lumbar spine for this claimant.

**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)