

# US Decisions, Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 5/8/08

**IRO CASE #:**

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

8 sessions of Physical Therapy

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

M.D., Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and Orthopaedic 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)

Upon independent review the reviewer finds that the requested 8 sessions of Physical Therapy are not medically necessary.

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

Adverse Determination Letters 4/2/08, 4/23/08  
ODG Guidelines and Treatment Guidelines  
URA Notes generated 4/22/08

Back Institute Comments 4/14/08  
Consultation 3/3/08  
Follow-Up 4/3/08  
Rehabilitation Services 3/3/08  
Medical Necessity 3/28/08  
Report of Medical Evaluation 1/18/08  
Review of Medical History and Physical Exam 1/18/08  
Physician Record 1/11/08, 3/2/07  
Pre-Authorization and Treatment Plan 3/30/07  
Initial Medical Report 3/2/07  
WC History  
Health Survey  
Pain Drawing  
Physical testing  
Task Lift Test  
Range of Motion  
Manual Muscle Test  
MRI 4/3/07

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

This is a xx year old woman (chef) injured on xx/xx/xx. Dr. described her having an emergency room visit on 2/19/07 for low back pain with acute sciatica. She had an MRI on 4/3/07 that showed a disc bulge at L5/S1 with moderate left and severe right intervertebral foraminal stenosis. An EMG reported bilateral L5 and right sided S1 radiculopathy. She had a translaminar epidural L5/S1 injection on 7/3/07 without relief. She developed a post procedure headache. A second epidural was reported as being unsuccessful on 1/17/08. The latter was felt to be a caudal injection. Dr. described her as having right sided LS tenderness, limited motion, with a positive right SLR. He planned for a right L5 selective nerve root block combined with a spinal stabilization program as an attempt to avoid lumbar surgery. The therapists felt there was a significant component of mechanical back pain present. She reportedly had worsening of her pain after therapy in 2007 and declined a course of work hardening. She had an FCE and was advised for sedentary work. Dr. wants a spinal stabilization program with myofascial release combined with the transforaminal epidural injection. The current request is for 8 sessions of physical therapy.

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

Upon review of the medical records provided and the corresponding ODG Guidelines, I find that the requested 8 sessions of physical therapy are not medically necessary. The patient has had physical therapy in the past and she reported it worsened her symptoms. The ODG is specific for the amount of therapy and it follows:

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. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#).

**Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):**

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

The situation is unchanged unless her symptoms improve after the transforaminal/selective nerve root injection. Looking forward, the proposed spinal stabilization program could prove beneficial if her pain is reduced by the injection, but presently the requested 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 & 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)**