



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

Notice of Independent Review Decision-WC

**DATE OF REVIEW: 2-2-09**

**IRO CASE #:**

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

Physical therapy 3-6 weeks

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

American Board of Orthopaedic Surgery-Board Certified

**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.

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

- 6-19-06 DC., provided a letter.
- 2-13-07 MD., office visit.
- 1-15-08 MD.
- 3-6-08 initial physical therapy evaluation.
- 3-19-08 MD., office visit.
- 3-28-08 MD., performed a Designated Doctor Evaluation.
- 11-24-08 MD., office visit.
- 12-11-08 Peer Review performed by DO.
- 1-5-09 MD., performed a Peer Review.

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

On 6-19-06, DC., provided a letter. The evaluator noted he had been the treating doctor for this claimant since 2-1-06. The claimant presented with low back pain, which had been constant since xx/xxxx. She had not been able to control the pain with medications. On initial exam, the claimant was found to have muscle spasm, swelling, heat and various subluxations in the lumbar and sacral area. The claimant was treated with chiropractic adjustments, and physiotherapies. The claimant had been treated 13 times and she had been steadily improvement.

Evaluation by MD., dated 2-13-07 notes the claimant had a work injury while working . On xx/xx/xx, she stepped backward on a cricket, and slipped sustaining a valgus twisting injury to her knee and her back. She had immediate pain. She has attempted to work, but was unable to do so. The claimant complains of pain and discomfort in her back with spasms at times. She reports the knee has gotten irritable to the extent that she sought chiropractic treatment, which has provided some relief. She has numbness and tingling beginning on the left side radiating into the thigh and lateral aspect of the leg. On exam, the claimant has full active range of motion, which the exception of lateral bend and lateral rotation bilaterally. There is mild paraspinal muscle weakness,

grade IV out of V and abdominal weakness similarly. There is spotty hypesthesia radiating into the flank, past the greater trochanter down onto the outside aspect of the left calf. Reflexes are bilaterally symmetrical and 2+. Impression provided included herniated nucleus pulposus, lumbar radiculopathy L4-L5-S1, lumbar radiculopathy, and lumbar spondylosis. The evaluator recommended Lidoderm patches, an MRI evaluation as well as an EMG/NCS. The evaluator recommended the claimant continue with chiropractic treatment. The evaluator recommended pain management for possible facet injections or epidural steroid injections.

On 1-15-08, the claimant underwent a neurosurgical consultation under the direction of MD. The claimant reported low back and left leg pain. On exam, the claimant is able to walk on heels and toes with normal strength. The evaluator noted the MRI of the lumbar spine shows mild bulge or fullness of the L4-L5 disc. The evaluator recommended lumbar epidural steroid block and physical therapy. The claimant was provided with Skelaxin and Tramadol.

On 3-6-08, the claimant underwent an initial physical therapy evaluation.

On 3-19-08, the claimant was evaluated by MD., due to complaints of low back pain with lumbar radiculopathy. On exam, the claimant had no paraspinal muscle spasm or tenderness. SLR was negative. DTR are equal. There were no motor or sensory deficits. The evaluator recommended obtaining all the claimant's previous studies and return for possible lumbar epidural steroid injections followed by physical therapy.

A Designated Doctor Evaluation performed by MD., on 3-28-08 notes the claimant was placed at MMI on 3-11-08 and was awarded 4% whole person impairment for the left knee based on partial meniscectomy of the medial aspect combined with joint space narrowing, for a total of 4% whole person. The evaluator did not feel the claimant had reached MMI for the lumbar spine. He reported that chiropractic therapy was not reasonable, as it only supplied temporary intermittent relief. He felt the claimant had a diagnosis of chronic sacroiliac strain and would benefit from a sacroiliac brace.

On 11-24-08, MD., evaluated the claimant. Diagnosis provided included left medial meniscus tear, chondromalacia medial femoral condyle and chondromalacia of patella. X-rays of the left knee shows degenerative findings, minimal type. Loss of medial vertical joint compartment height.

On 12-11-08, a Peer Review performed by DO notes the denial for an MRI of the lumbar spine. The reviewer reported the claimant has a known HNP. There was no evidence in change in her clinical neurologic condition to require another MRI. The evaluator also denied the request for an EMG/NCS. The evaluator reported that the request for physical therapy was unreasonable. This claimant had an injury that was xx year old and she should be performing a home exercise program.

On 1-5-09, MD., performed a Peer Review. The evaluator did not approve an MRI of the lumbar spine. The evaluator did not approve an EMG/NCS. The evaluator did it feel that physical therapy to the lumbar spine was reasonable or necessary.

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

MEDICAL RECORDS REFLECT A CLAIMANT WITH AN INJURY THAT IS ALMOST XX YEARS OLD TO THE LUMBAR SPINE WITHOUT ANY EVIDENCE OF SIGNIFICANT PATHOLOGY. THERE IS REPORTED LUMBAR BULGE AT L4-L5. THERE IS NO EVIDENCE OF RADICULOPATHY IN PHYSICAL EXAMS THROUGHOUT THE YEARS.

THE CLAIMANT HAS HAD CHIROPRACTIC THERAPY IN THE PAST TO INCLUDE PHYSIOTHERAPY WITH REPORTED SHORT TERM IMPROVEMENT. AT THIS TIME, ALMOST 10 YEARS POST INJURY, THERE IS NO INDICATION FOR PHYSICAL THERAPY NOR SUPPORT FOR PHYSICAL THERAPY IN CURRENT EVIDENCE BASED MEDICINE. THEREFORE, PHYSICAL THERAPY 3-6 WEEKS IS NOT EVIDENT.

**ODG-TWC, last update 12-31-08 Occupational Disorders of the Low Back – Physical therapy:**

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, including assessment after a "six-visit clinical trial".

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):

10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846):

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5):

9 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)**