



Notice of Independent Review Decision

DATE OF REVIEW: 6/19/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for physical therapy 3 times a week for 4 weeks, for the lumbar spine with 97140, 97530, 97112, 97110, 97002, 97022, 97035, A4556, and G0283.

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

Texas licensed Family Practice 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 3 times a week for 4 weeks, for the lumbar spine with 97140, 97530, 97112, 97110, 97002, 97022, 97035, A4556, and G0283.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Texas Department of Insurance Fax Cover Sheet dated 6/9/09.

- Notice to CompPartners, Inc. of Case Assignment Sheet dated 6/9/09.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization Sheet dated 6/9/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization Form dated 6/8/09.
- Request for a Review by an Independent Review Organization Form dated 6/8/09.
- Initial Evaluation Sheet dated 3/6/09, 3/4/09.
- Physical Therapy Discharge Summary Sheet dated 6/3/09.
- Texas Workers' Compensation Work Status Report dated 5/27/09, 4/27/09, 4/7/09, 3/25/09, 2/25/09, 2/11/09, 2/4/09, (unspecified date).
- Review Summary dated 5/11/09.
- Notification of Determination summary dated 4/16/09.
- Ambulatory Preventive Care Review Sheet dated 5/27/09, 4/27/09, 4/7/09, 3/25/09, 2/25/09, 2/11/09, 2/4/09, 1/28/09.
- Pre-Certification for Physical Therapy Sheet dated 4/10/09, 3/5/09.
- Letter of Appeal 5/4/09.
- Progress Report dated 4/29/09.
- Re-Evaluation Sheet dated 4/10/09.
- MRI Report dated 3/25/09.
- Referral for Rehabilitation Sheet dated 2/25/09.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Moving truck batteries onto a dolly and developed low back pain.

Diagnosis: Low back pain, piriformis syndrome, L5-S1 annular tear, and lumbar disk bulges.

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

This male was injured on xx/xx/xx when he was moving truck batteries onto a dolly. His diagnosis was low back pain, piriformis syndrome, L5-S1 annular tear, and lumbar disk bulges. The injured worker was treated with 10 physical therapy visits and Amrix, Vicodin, Carisoprodol, and a Medrol Dosepak. On March 25, 2009, an MRI of the lumbar spine was performed. It revealed a 4-mm broad-based disk bulge at L2-L3 with minimal central canal stenosis and minimal narrowing of the bilateral neural foramen. At L5-S1, there was an annular disk tear and a mild broad-based disk bulge. There was mild narrowing of the left

neural foramen. A review of Dr. 's progress notes between February 2009 and May 2009, documented subjective complaints of low back pain. He had a positive straight leg raise, but normal range of motion and strength. Some of the notes made nonspecific mention of left lower extremity symptoms. Dr. diagnosed the patient with low back pain, left piriformis syndrome, lumbar disk bulges, and an L5-S1 annular tear. He discussed the patient's left lower extremity symptoms and recommended a referral for possible injection. He did not specify if the injection was for the piriformis syndrome, a lumbar epidural steroid injection, or some other type of injection, such as a trigger point injection. On May 27, 2009, his progress note indicated that he felt the patient should get an attorney if he was "unable to get (something illegible) care." He was prescribed 18 visits of physical therapy on 2/25/09. During the initial physical therapy (PT) evaluation on 3/4/09, the patient was noted to have no balance deficits, normal range of motion and no focal weakness. He had a lifting restriction of 20 pounds. According to his PT discharge summary from 6/3/09, the claimant had basically the exact same findings except his was not lifting more than 15 pounds. According to the physical therapist's appeal letter, dated May 4, 2009, an additional six visits were being requested. The therapist stated that the injured worker's pain decreased from 6 to 3/10 and his "back index" went from 46% to 38%. His range of motion was now within normal limits. After reviewing all of the clinical information provided, the denial for a continued PT was upheld. The Official Disability Guidelines recommend "10 visits over 8 weeks" for intervertebral disk disorders without myelopathy and for lumbar sprains and strains. Piriformis syndrome is not specifically addressed by the guidelines, but the 10 visits provided would be reasonable. The injured worker continued to have pain that was rated 3/10. However, his range of motion and strength were within normal limits throughout the course of therapy. He should be able to continue with an independent home exercise program. If his primary symptoms continued to be lower extremity pain, this could be consistent with radiculopathy. The ACOEM Guidelines state, "If a patient fails to functionally improve as expected with treatment, the patient's condition should be reassessed in order to identify incorrect or missed diagnoses. Further treatment should be appropriate for the diagnosed condition(s), and should not be performed simply because of continued reports of pain." He was referred for possible injections. If epidural steroid injections were performed, then it would be reasonable to provide one to two visits in the week following an injection. However, the records did not indicate that the patient actually was ever sent to a specialist for evaluation for injection. Again, at this point, an independent home exercise program is appropriate. The guidelines state, "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." There are no specific range of motion deficits that need to be addressed with therapy since the patient had normal range of motion. He still experienced pain with lifting, but it was not clear to this reviewer that formal physical therapy is necessary for this reason primarily. Furthermore, in the 10 visits provided, he did not increase his lifting ability. It actually appeared to decrease by 5 pounds. If radiculopathy is causing the majority of the pain symptoms, then physical therapy is unlikely to resolve this problem anyway. Perhaps the patient might be treated with medication for neuropathic/radicular pain or have invasive procedures such as injections as possible treatment options. Sometimes piriformis syndrome is also treated with

injections if stretching exercises and another conservative measures, such as non-steroidals are not effective. Because the patient already exceeded the guideline recommended number of visits and based on the explanation provided, the adverse determination was upheld for additional therapy. All of the corresponding CPT codes were also denied since therapy was not recommended.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.

American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Second Edition, Chapter 6, page 115. General (pain)-Inappropriate continuation of ineffective treatment.

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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES. Official Disability Guidelines, Web Based Version, 7th Edition, 2009, Low Back. PT.

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).