US Decisions Inc.

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DATE OF REVIEW:
Jun/12/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy 3 Times per week for 4 weeks for the Lumbar.

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG Guidelines and Treatment Guidelines
Determination Letters, 4/6/09, 5/14/09
EMG/NCS Report: 10/28/08
MRI Report: 1/10/08
Office Note, Dr.: 12/11/08 and 05/04/09
Peer Review, Dr. 12/17/08
Office Note, Dr.: 03/11/09 and 05/05/09
Office Note, Dr.: 03/11/09
Letter: 04/06/09 and 05/14/09
Letter, Dr. 04/20/09
Authorization Request: 05/07/09

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male who felt pain in his low back on xx-xx-xx. The claimant reported right lower extremity pain. Electrodiagnostic studies conducted on xx-xx-xx indicated lumbar radiculopathy involving the right S1 nerve root. Lumbar MRI evaluation performed on 11/10/08 noted L4-5 extremely subtle left paracentral disc protrusion and annular tear superimposed on spondylosis and annular bulge with mild bilateral lateral recess narrowing, left greater than right; no central canal stenosis; and bilateral neural foraminal narrowing at L4-5 and L5-S1 without compression on the exiting L4 or L5 nerve root sheaths. Dr. saw the claimant on 12/11/08 with physical examination findings of “a little” right tibialis anterior and extensor hallucis longus weakness. Reference was made to prior epidural steroid injection and recommendation was made for another injection. A peer review on 12/17/08 outlined prior chiropractic management from 08/26/08 to 11/11/08 and two sessions of physical therapy approved on 10/06/08 to establish and monitor a home exercise program.

Dr., a chiropractor, saw the claimant on 03/11/09 for worsening low back pain, right radicular pain and depression. The claimant underwent chiropractic modalities and remained off work. Dr. saw the claimant for pain management evaluation on 03/11/09 with notation the claimant had continued to treat with medications and injections as needed. The claimant was continued on Norco, Soma and Neurontin. On 04/06/09 additional chiropractic modalities of neuromuscular reeducation, therapeutic exercises and manual therapy were denied. A letter by Dr. on 04/20/09 indicated Dr. did not feel the claimant was a surgical candidate. On 05/04/09 Dr. indicated the claimant truly had radicular right leg pain and recommended CT/ myelogram evaluation. On 05/07/09 chiropractic neuromuscular reeducation, therapeutic exercises and manual therapy three times a week for four weeks was requested.

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

The evidence based ODG guides suggest that physical therapy is an option for the management of low back injuries. The guidelines allow for fading frequency of treatment over a short course of treatment. On most occasions individuals should reach their maximum benefit within 10 visits following which they can transition to a home exercise program. The records reflect that this claimant had already completed at least nine sessions of therapy. Twelve additional sessions are requested. At ten months following the date of injury, it would be difficult to suggest that this number of additional physical therapy sessions would be medically necessary. There is no indication that further chiropractic would be reasonable or medically necessary. The evidence based literature has not shown proven benefit in chronic cases and based on the history of chiropractic to date there would be no indication for further chiropractic at this juncture. The reviewer finds that medical necessity does not exist for Physical Therapy 3 Times per week for 4 weeks for the Lumbar.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates; Low Back-Manipulation and Physical Therapy

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

[ ] ACOEM-AMERICA 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

[X] 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

[ ] 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)