

Notice of Independent Review Decision

REVIEWER'S REPORT

**DATE OF REVIEW:** 11/20/09

**IRO CASE #:**

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

Physical therapy, three sessions per week for two weeks

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.O., duly licensed physician in the State of Texas, fellowship-trained in Pain Management, Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine, with over 22 years of active and current experience in the practice of Pain Management

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
722.93	97140		Prosp.						Upheld
	97112		Prosp.						Upheld
	G0283		Prosp.						Upheld
724.4	97110		Prosp.						Upheld

**INFORMATION PROVIDED FOR REVIEW:**

- Lumbar MRI scan dated 08/21/07
- Electrodiagnostic study, 04/09/08
- Progress notes from Dr., 06/10/08 and 07/10/08
- Initial evaluation from Dr., 08/28/09
- Physical Performance Evaluation, 09/02/09
- Physical therapy evaluation, 09/04/09
- Physical Adviser Reports, 09/15/09 and 10/14/09
- Letters for request for reconsideration from Dr., 09/16/09 and 10/14/09

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

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This claimant was injured in xx/xx while working. He twisted his back and felt pain in the low back. Lumbar MRI scan on 08/21/07 demonstrated diffuse disc bulges at L3/L4, L4/L5, and L5/S1 with mild bilateral foraminal stenosis at L3/L4, moderate left foraminal stenosis at L4/L5, mild canal stenosis at L4/L5, disc dehydration at L5/S1, and small annular tear with mild to moderate bilateral foraminal stenosis at L5/S1. Electrodiagnostic studies were then performed on 04/09/08, demonstrating no evidence of radiculopathy.

On 06/10/08 the claimant was evaluated, at which time his complaints of lumbar pain radiating to the left leg, swelling and pain of the entire left side were noted. The patient has previously undergone two epidural steroid injections, which only helped for a week, after which the pain returned with a “vengeance,” causing the claimant to be in more pain than he was before the injection. At that point the claimant suggested that he be sent physical therapy rather than do more epidural steroid injections.

On 07/10/08 follow up, the claimant, noted his continued unchanged lumbar and left leg complaint, now with numbness and weakness and constant pain in the left leg. Despite documenting only one month before the failure of epidural steroid injections, she recommended that the claimant undergo more.

On 08/28/09 the claimant was evaluated and his complaint of lumbar pain now radiating into both legs was noted. Physical examination documented no spasm, nonspecific left paraspinal tenderness, positive left straight leg raise, decreased left L5/S1 sensation, and normal reflexes bilaterally. The physician recommended the claimant complete ten sessions of physical therapy.

On 09/02/09 a physical performance evaluation was performed, documenting the claimant’s continued lumbar and left leg pain with a pain level of 7/10 as well as intermittent left foot numbness. The claimant reported no significant relief with heat, rest, muscle rub, or pain medication. Examination documented limitation in all lumbar range of motion and deficits in strength of all left leg muscles.

On 09/04/09, a physical therapy evaluation was completed, noting the claimant’s complaint of constant lumbar pain radiating into both legs. A physical therapist noted a claimant had completed four physical therapy sessions by 05/22/08 and six “post injection” physical therapy sessions as of 07/02/08 for a total of ten sessions. A request was then submitted for the claimant to undergo two weeks of physical therapy three times per week.

An initial Physician Adviser Review on 09/15/09 recommended nonauthorization of the request, citing ODG Treatment Guidelines and lack of documented clinical benefit from previous physical therapy. The treating doctor wrote a letter to request reconsideration. He noted ODG Guidelines recommending ten to twelve physical therapy sessions and six sessions of “post injection” physical therapy to total sixteen to eighteen visits. He stated the claimant had only undergone four physical therapy visits before epidural steroid injections and then six physical therapy visits after the epidural steroid injections.

A second Physician Adviser reviewed the request on 10/14/09, recommended nonauthorization. The adviser again cited ODG Treatment Guidelines of recommended ten physical therapy sessions over eight weeks for intervertebral disc disorder without myelopathy and one to two post injection treatments for one week following injections. The Physician Adviser also noted that there was no documentation of objective functional progress from physical therapy and that extension of therapy was only reasonable if objective functional gains could be documented.

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

According to ODG Treatment Guidelines, ten physical therapy sessions over an eight-week period are considered medically reasonable and necessary for a diagnosis of intervertebral disc disorder without myelopathy. This is the correct diagnosis for this claimant, as the claimant has not physical examination

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evidence of myelopathy and no evidence of radiculopathy on EMG studies. The Guidelines do not state that additional physical therapy should be provided beyond the ten sessions for post injection therapy.

Since this claimant only had two epidural steroid injections, no more than two to four physical therapy sessions would have been appropriate for “post injection therapy,” although this claimant had six. Additionally, the claimant completed four sessions of physical therapy before epidural steroid injections by May 2008. Therefore, this claimant has completed the appropriate amount of physical therapy as prescribed by ODG Treatment Guidelines, which state that ten sessions over eight weeks will be appropriate. Since it is now well over two years following the lumbar strain/sprain event, there is no ODG support or necessity for the claimant to now undergo further physical therapy, as it is well beyond the eight-week stipulated time period.

Additionally, as has been pointed out by the previous Physician Advisers, there is no documentation of this claimant obtaining any clinically significant benefit from any of the ten physical therapy sessions which have already been provided, both before and after epidural steroid injections. Therefore, according to ODG Treatment Guidelines, and given the amount of time which has elapsed since the claimant’s alleged injury in xx/xx, there is no medical reason or necessity nor ODG Treatment Guidelines support for the requested two weeks of physical therapy three times per week. The claimant has completed an appropriate amount and trial of physical therapy according to ODG Treatment Guidelines without any documented objective evidence of improvement. In fact, given the fact that the claimant’s current pain complaints are no different than they were well over a year ago, the only logical conclusion that can be reached is that all treatment including physical therapy has not provided any clinically significant benefit. Therefore, the recommendations for nonauthorization by the previous Physician Advisers are upheld, and the request for three sessions of physical therapy per week for two weeks is not medically reasonable or necessary and, therefore, should not be authorized.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
  - \_\_\_\_\_ Mercy Center Consensus Conference Guidelines.
  - \_\_\_\_\_ Milliman Care Guidelines.
  - XX \_\_\_\_\_ 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 national accepted medical literature (provide a description).
  - \_\_\_\_\_ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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