MEDR X

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Notice of Independent Review Decision

DATE OF REVIEW: 11/23/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of 12 physical therapy visits to the lumbar spine.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This review was performed by a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This provider performs this service in practice and has been practicing for greater than 15 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of 12 physical therapy visits to the lumbar spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
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PATIENT CLINICAL HISTORY [SUMMARY]:
The injured employee is a female who sustained a work related injury to the lower back xx/xx/xx. Dr. saw the patient xxxx, noting that she still had persistent back pain with radiation to the right leg. Pain radiated over toward the right hip and down in the right lateral thigh, to the knee and chest below. MRI of the pack revealed multileveled disc degeneration,

especially at L3-L4 and at L4-L5, with great one spondylolisthesis. There was no bowel or bladder dysfunction. Physical examination revealed normal gait and motors. Straight leg raising was negative. Dr. diagnosed low back pain and trochanteric bursitis on the right. A cortisone shot to the right hip was recommended.

A physician reviewer documented that the injured employee had six sessions of P.T. to the lumbar spine approved June 8, 2009. On 08/04/09 a general note was submitted by R.N. at xxxxx., documenting that the patient had submitted an e-mail 7/29/09, stating that the lower back pain persisted. A physician reviewer documented that 4 sessions of P.T. to the lumbar spine were approved August 4, 2009.

Dr. saw the injured employee 09/04/2009 for follow-up evaluation of low back pain and left leg pain. The left side pain radiated down to the heel and then to the forefoot. Occasionally, it went down to the right leg, to the back and the anterolateral aspect of the leg. The main problem was the left leg. Examination revealed tenderness in the lumbar spine. Ankle jerks and knee jerks were absent. There was no paralumbar spasm, no sciatic notch tenderness, no sacroiliac joint tenderness, negative straight leg raising bilaterally, negative Lasegue's test, no weakness on muscle strength testing of the lower extremities, no atrophy noted, no calf tenderness, intact peripheral pulses and sensation. Dr. diagnosed lumbar radiculopathy and recommended physical therapy, with follow-up in 4 to 6 weeks. Stating that if she does not prove, epidural steroid injections or surgical intervention may be indicated in the future.

On 09/04/2009 the order for "P.T. Low Back Pain", three times per week for four weeks, was documented by at xxxxxx.

On 10/14/2009 Dr. saw the patient regarding low back and left leg pain, noting that she had had no physical therapy since July since it was denied by the insurance company. Dr. noted that an EMG by Dr. in August 2008 was normal. Another EMG in May, performed by Dr. was mentioned, but this may have been an upper extremity EMG. Examination revealed tenderness across the lumbar spine, with negative straight leg raising and Lasegue's. Her calf was nontender, Homan sign negative, circulation intact. Range of motion of the hip did not hurt. She had no cellulitis or lymphadenitis. Dr. diagnosed acquired spondylolisthesis L4-L5 with a bulge of the disc and moderate spinal stenosis, with lumbar radiculopathy. He recommended that the patient obtain copies of the EMG report. He recommended an epidural steroid injection (ESI) at the L4-L5 level.

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

1. According to the ODG physical therapy guidelines for Sciatica: Thoracic/lumbosacral Neuritis/radiculitis, unspecified (ICD9 724.3; 724.4): 10-12 visits over eight weeks. In addition to the 10 therapy visits previously authorized (apparently only six visits were done), 12 additional visits (three times a week for four weeks), were requested. The proposed therapy exceeds the recommended amount.

   - Six P.T. visits for the lumbar spine were authorized June 8, 2009. No clinical records pertaining to the results of the treatments was available for review exceP.T. for the general note on 08/04/09,submitted by R.N. at xxxx xxxx, P.A., wherein Ms. stated in an e-mail 7/29/09 that the lower back pain persisted. Ms. requested continuing P.T. treatment.
   - Four P.T. visits for the lumbar spine were authorized August 4, 2009. No clinical

records were submitted regarding the outcome of those treatments. Dr. indicated in his clinical note October 14, 2009 that Ms. had received no physical therapy since July. One physician reviewer noted that Ms. did not complete four visits as she was going to Europe.

2. According to the ODG guidelines pertaining to physical therapy:

- Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program…
- Within four visits, the patient must display documented improvement in order to continue therapy. If no improvement is noted, a comprehensive re-evaluation should be performed….
- Continued improvement must be documented for continued therapy. Typically no more than four to six visits are needed.
- Somewhere between 9 and 12 visits or between 4 and 6 weeks the patient should be reassessed.
- Generally, the number of weeks recommended should fall within a relatively cohesive time period, between date of first and last visit, but this time period should not restrict additional recommended treatments that come later, for example due to scheduling issues or necessary follow-up compliance with a home-based program. *Comment: The initial six P.T. treatments were done before July 2009. Those treatments therefore would not be counted together with any proposed future treatments, as the guides recommend that the course of treatment should occur within 10-12 weeks.*

The request does not comply with the ODG guidelines and is therefore 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)**