



DATE OF REVIEW: 10/07/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Physical therapy, multiple modalities and procedures, three times a week for six weeks

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine problems

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. ZRC forms
2. TDI referral forms
3. Denial letters 07/27/09 and 08/25/09
4. URA records including therapy reports 07/14/09
5. Request for continued physical therapy, 08/17/09
6. Evaluation, M.D., 07/23/09

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This male suffered an injury to the lumbar spine region on xx/xx/xx. He was working in a boiler unit in a confined space when a piece of the metal plate came off, striking him in the left hip. He suffered lumbar and left hip strain, a peroneal nerve palsy, and low back pain and left leg pain. He further suffered a partial peroneal palsy. At some point a partial laminectomy at L4/L5 and microdiscectomy at L4/L5 were performed. The surgery was performed on 05/29/08. He has received approximately 25 sessions of

postoperative physical therapy. Additional physical therapy has been requested. The request has been evaluated and denied, reconsidered and denied.

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

The manifestations of the peroneal nerve palsy are, in fact, improving. Strength is returning. The patient has received the physical therapy regimen, which is appropriate in the postoperative period after a partial laminectomy and discectomy. Additional physical therapy is not justified. The prior denials were appropriate and should be upheld.

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

(Check any of the following that were used in the course of your review.)

- 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.
- ODG-Official Disability Guidelines & Treatment Guidelines, 2009, Low Back Chapter, Physical Medicine passage
- 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.)