



INDEPENDENT REVIEW INCORPORATED

DATE OF REVIEW: 09/27/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Denial of continued physical therapy two times per week for four weeks

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified in Physical Medicine and Rehabilitation and member of North American Spine Society

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)

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letters of denial, 08/03/09 and 08/14/09
3. Pain Management and Rehabilitation evaluation, 01/21/09
4. Pain Management office visits, 12/18/08-07/09/09 (nine visits)
5. Physical therapy initial evaluation, 06/16/09

<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			<i>Prosp.</i>						<i>Upheld</i>

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This injured employee has a history of a back injury while he was working . At that time the patient experienced severe lower back pain and was diagnosed with an L3/L4 and L4/L5 herniation. He has a history of an L5/S1 discectomy and has developed chronic pain. He has seen multiple physicians for both his surgery and pain management. He has undergone several procedures and is on chronic opioid analgesic therapy. In the medical records, he has a diagnosis of lumbar disc displacement without myelopathy as well as chronic pain syndrome. This patient has also participated in physical therapy.

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

On review of this case and following the Official Disability Guidelines and Treatment Guidelines focusing in the chapter on back pain, this patient has had a reasonable trial of physical therapy, and considering the length of time from his initial injury and surgery, should be successful with a self-guided exercise program. The evidence for such a program is supported by the aforementioned Official Disability Guidelines as well as multiple randomized and peer-reviewed trials. In addition to these references, one may also reference Dr. Physical Medicine and Rehabilitation textbook for further evidence of self-guided therapy program at this juncture.

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.
 - 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 (Randall Braddom's Physical Medicine and Rehabilitation textbook)
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