



791 Highway 77 North, Suite 501C-316 Waxahachie, TX 75165  
Ph 972-825-7231 Fax 972-775-8114

### Notice of Independent Review Decision

**DATE OF REVIEW:** 4/19/2010

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of Physical Therapy 2 x Wk x 3 Wks (97535, 97110, 97530).

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer 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 Physical Therapy 2 x Wk x 3 Wks (97535, 97110, 97530).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

DO

These records consist of the following (duplicate records are only listed from one source):  
Records reviewed from DO: History and Physical – 11/30/09, Follow-up Notes – 12/21/09-3/15/10, Various DWC73s.

Records reviewed: Denial letters – 3/4/10 & 3/24/10; Injury 1 Pre-auth request – 3/1/10, Patient Face Sheet – 3/1/10, Eval & Treat script – 2/22/10, Re-Eval report – 2/24/10, Reconsideration request – 3/15/10.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient sustained a work related injury to the lower back xx/xx/xx. According to the records from the office of Dr., the patient was initially seen by the company nurse and returned to work. That evening he was seen at xxxxx xxxxx xxxxx and treated for sprain/strain with Vicodin and muscle relaxers.

On 11/30/09 the patient was seen by P.A. at the office of Dr. for evaluation and treatment. A diagnosis of lumbar sprain/strain was made. Physical therapy was requested. An appointment was made to see Dr. as soon as possible. The patient was allowed to continue to work.

On a follow-up visit 12/21/09 the patient saw Mr. for follow-up. He was also seen by Dr. who diagnosed lumbar sprain/strain and possible lumbar herniated disc, L4-L5 and L5-S1, with clinical left lumbar radiculopathy. Dr. recommended no work for 30 days, noting that the patient "has been terminated from his place of employment". Physical therapy evaluation and treatment was requested. Dr. requested and MRI of the lumbar spine and EMG/NCV of the left lower extremity. He prescribed Darvocet N and Lyrica.

On a follow-up visit 02/01/10 the patient continued to have pain. MRI of the lumbar spine dated 1/18/2010 was reported to show disc protrusions at L3-L4, L4-L5, and at L5-S1. 2. The EMG report was not available for review. Darvocet was discontinued because of side effects. Prescriptions were written for tramadol and Elavil.

On 2/24/2010 the patient was seen by Dr. for re-evaluation.

Dr. noted that the patient had improved but that he continued to experience deficits. He was scheduled for orthopedic consult with Dr. on March 17, 2010. He had evaluation for an injection evaluation with Dr. on 2/23/2010 and was awaiting the results. Dr. noted that the patient would benefit from additional rehab focusing on progressive resistance and strengthening. Further therapy was requested.

On the follow-up visit 3/01/2010 Mr. noted that the pain persisted. The MRI and the EMG had documented S1 nerve root compression. Examination revealed positive left straight leg raising with spasms and tenderness in the lumbar spine and with decreased lumbar range of motion. The plan was to continue off work pending further neurosurgical evaluation, continue the current medications, to have the scheduled epidural steroid injections "tomorrow", and to return for follow-up in one month.

The requested therapy sessions were non-certified 3/4/2010. The noncertification was upheld on appeal 3/24/2010. The PA note dated 3/1/10 indicated that the claimant was seen for low back pain and left lower extremity numbness, reporting pain and discomfort radiating

from the left side of the back into the left testicle. MRI and EMG reportedly demonstrated evidence of S1 nerve root compression. Straight leg raising test was positive. Lumbar range of motion was decreased. It was noted that the claimant was scheduled to undergo epidural steroid injections.

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

According to the records reviewed above, the patient has had symptoms and clinical signs of lumbar radiculopathy, with abnormal findings on imaging studies and electrodiagnostic studies. Furthermore, according to the clinical notes from 3/01/2010, epidural steroid injection and neurosurgery evaluation was pending.

According to the ODG general 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.

Dr. 2/24/2010 clinical records mentioned an improvement in response to the treatments, but he noted that the patient continued to experience deficits. Dr. further noted that arrangements had been made for orthopedic evaluation and for injection evaluation. On 3/01/2010, Mr. noted that the patient would continue off work pending further neurosurgical evaluation, continue the current medications, and have the scheduled epidural steroid injection "tomorrow." Apparently the injection was scheduled for 3/02/2010, but no record was submitted to document that the injection was done. No records were received pertaining to the outcome of the orthopedic or neurosurgical evaluation. Therefore the comprehensive re-evaluation may not have been completed. Therefore, the requested procedure is 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 KNOWLEDGBASE**

**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)**