

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Nov/30/2010

**IRO CASE #:**

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

12 visits of physical therapy to the low back over 6 weeks including #97140, #97110, #97014, #97010, #97035, #97535, and #99070

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

M.D., Board Certified Orthopedic Surgeon

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Dr. office notes 08/19/10, 09/07/10, 09/15/10, 10/21/10,

MRI lumbar spine 09/10/10

Physical therapy prescription 10/21/10

Physical therapy evaluation 10/21/10

Physical therapy daily progress notes 10/22/10, 10/27/10, 11/02/10, 11/10/10

Peer review reports 10/25/10, 11/05/10

Letters 11/03/10, 10/25/10, 11/05/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male with a reported injury of xx/xx/xx when he was picking up a TV to mount onto the display rack. The claimant was evaluated by Dr. on 08/18/10 for low back pain. MRI of the lumbar spine on 09/10/10 showed a 5-6 millimeter central to right central disc protrusion to herniation with 2-3 millimeter impression on anterior thecal sac at L5-S1. Records indicate that the claimant was referred for neurosurgical evaluation and received an injection to his low back with some benefit. Twelve visits of physical therapy were ordered on 10/21/10. Physical therapy was denied on peer review. It appears that the claimant had four sessions of therapy between 10/22/10 and 11/10/10.

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

The evidence-based Official Disability Guidelines recommend physical therapy as an adjunct to treatment for back pain. In general, most individuals can be successfully rehabbed with a short course of therapy, but in some individuals, up to nine visits over eight weeks can be reasonable and appropriate. The evidence-based guidelines also address specific interventions by the therapist in conjunction with that type of treatment.

This review was to determine whether or not the request for 12 visits of therapy would be medically necessary. This request would not appear to be medically necessary, as it would lie outside the typical number of visits recommended by Official Disability Guidelines. The ODG would recommend up to six visits of therapy to determine whether or not the claimant was making reasonable progress, following which additional therapy could be indicated.

Evidence-based guidelines support the use of manual therapy, therapeutic exercise, and home care training. The ODG does not recommend utilization of modalities such as electrical stimulation, hot and cold packs, and ultrasound in this particular setting, as they are not well supported in the evidence-based literature. Therefore, the reviewer finds that medical necessity does not exist for 12 visits of physical therapy to the low back over 6 weeks including #97140, #97110, #97014, #97010, #97035, #97535, and #99070.

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Updates. Low Back:

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial"

Lumbago; Backache, unspecified (ICD9 724.2; 724.5)

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8)

Medical treatment: 10 visits over 8 weeks

The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530).

Cold/heat packs

Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs.

## Ultrasound

Not recommended based on the medical evidence, which shows that there is no proven efficacy in the treatment of acute low back symptoms. However, therapeutic ultrasound has few adverse effects, is not invasive, and is moderately costly, so where deep heating is desirable, providers and payors might agree in advance on a limited trial of ultrasound for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care including exercise (but it is still not recommended by ODG). Therapeutic ultrasound is one of the most widely and frequently used electrophysical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing

### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

**ACOEM-AMERICA 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)**