

INDEPENDENT REVIEWERS OF TEXAS, INC.

4100 West El Dorado Pkwy · Suite 100 – 373 · McKinney, Texas 75070

Office 469-218-1010 · Toll Free 1-877-861-1442 · Fax 469-218-1030

e-mail: independentreviewers@hotmail.com

Notice of Independent Review Decision

DATE OF REVIEW: 01/27/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Outpatient physical therapy 12 sessions to the lumbar spine with electrical stimulation, therapeutic exercise, therapeutic activities, ultrasound, manual therapy, massage therapy not to exceed 4 units per session.

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

Texas Board Certified Neurosurgeon

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Radiographs of the lumbar spine dated 03/21/07
2. Clinic notes dated 03/30/07-05/08/07
3. MRI lumbar spine dated 05/18/07
4. Orthopedic note dated 07/05/07
5. MRI cervical spine dated 08/07/07
6. Electrodiagnostic studies dated 09/21/07
7. Physical therapy evaluation dated 10/10/07
8. Utilization review determination dated 10/16/07
9. Procedure notes dated 12/07/07 and 01/18/08
10. Follow-up notes dated 01/03/08 and 01/31/08
11. History and physical dated 02/13/08
12. Operative note dated 02/13/08
13. Radiographs lumbar spine dated 02/13/08
14. Follow-up notes dated 03/06/08-07/21/08
15. Admission assessment dated 07/29/08
16. Operative note dated 07/29/08
17. Follow-up note dated 08/07/08
18. Discharge summary dated 08/27/08
19. Pathology report dated 08/27/08
20. ER report dated 09/07/08
21. Follow-up notes dated 09/18/08-06/01/09
22. MRI lumbar spine dated 06/18/09
23. Follow-up note dated 10/01/09

- 24. IME dated 11/12/09
- 25. Physical therapy evaluation dated 11/30/09
- 26. Utilization reviews dated 12/04/09 and 12/24/09
- 27. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx when he was involved in a motor vehicle accident.

The initial MRIs demonstrated an early lateral disc herniation at the L5-S1 level with no significant findings in the cervical spine. The employee had electrodiagnostic evidence of a left sided S1 radiculopathy and was initially not approved for physical therapy.

The employee underwent epidural steroid injections that did provide temporary relief of pain in January of 2008.

The employee continued to experience symptomatic low back pain and radiating lower extremity pain and underwent left L5-S1 laminectomy and decompression on 02/13/08. Postoperatively, the employee had mild residual back pain and did not attend postoperative physical therapy.

The employee developed a pocket of subcutaneous fluid in the upper portion of the lumbar incision. Initially, there was no evidence of infection, and the employee underwent aspiration of fluid. This was performed on 07/29/08. The fluid appeared to be cerebral spinal fluid with the possibility of a small fistula.

The employee then underwent an exploration of the lumbar laminectomy incision on 08/27/08. Postoperative follow up on 09/18/08 stated the employee was now doing well with no evidence of infection or continued fluid collection. The employee stated he was ready to return to work.

Follow-up notes through April of 2009, demonstrated the employee had mild lumbar pain only with no radiating pain. The employee had intact strength in the lower extremities and only took occasional pain medications. The employee had not yet returned to work.

A follow-up note dated 06/01/09 stated the employee had developed significant chronic mechanical low back pain with aching in the hips and legs. The employee was recommended for a repeat MRI study.

An MRI of the lumbar spine dated 06/18/09 reported multilevel degenerative disc disease and spondylosis in the lumbar spine with prior laminectomy changes at L5-S1. Possible pars defect at L5 was noted. Evidence consistent with a pseudomeningocele was noted. No further procedures were recommended.

An Independent Medical Evaluation (IME) dated 11/12/09 reported the employee had a slow but otherwise normal gait and can perform heel and toe walking. Discomfort was noted on spinal extension and flexion. Reflexes were symmetric and sensation was

intact. The employee was placed at clinical Maximum Medical Improvement (MMI) at this visit.

A physical therapy evaluation dated 11/30/09 reported the employee had intact range of motion of the lumbar spine with mildly reduced strength. The employee was recommended for physical therapy.

Prior determinations for twelve physical therapy sessions to included e-stim, exercises with ultrasound and manual therapy dated 12/04/09 and 12/24/09 stated that the request was not medically necessary as it was unclear why the employee would not be on an active independent home care program and that physical therapy was not an effective approach to chronic pain situations.

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

The employee is status-post lumbar laminectomy and decompression performed in 2008. The employee did have postoperative complications; however, records noted the employee appeared to be symptom free until June of 2009. The employee was not recommended for any additional surgery, and the most recent physical therapy evaluation demonstrated no significant functional deficits that would require additional therapy at this time. Per ***Official Disability Guidelines***, home exercises are encouraged and supported for treatment for employees with chronic low back pain. It is also recommended in the ***Official Disability Guidelines*** that physical modalities are shown to have better clinical outcomes versus passive therapy.

The requested twelve sessions includes both active and passive modalities which would not be supported by the ***Official Disability Guidelines***. Additionally, as the employee's most recent evaluation does not demonstrate any significant functional limitations, physical therapy would not be indicated. It is also unclear if the employee has an established home exercise program as supported within the ***Official Disability Guidelines***. Given that the submitted clinical documentation does not support the request for twelve sessions of physical therapy with both active and passive modalities, medical necessity at this time is not established, and the prior determinations are upheld.

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

1. **Official Disability Guidelines**, on-line version, Low Back Chapter