

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: January 13, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Six sessions of physical rehabilitation in the form of physical therapy to the low back for two weeks at a frequency of three times per week to include CPT codes 97110, 97140 and 97112.

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

Diplomate, American Board of Physical Medicine and Rehab

Fellow, American Academy of Disability Evaluation Physicians

Texas State Designated Doctor

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

Medical records from the Carrier include:

- xxxxx, 01/08/03
- M.Ed., L.P.C., 06/06/03
- D.C., 07/07/03, 07/08/03, 07/10/03, 07/11/03, 07/14/03, 07/15/03, 07/16/03, 07/17/03, 07/18/03, 07/21/03, 07/22/03, 07/23/03, 07/29/03, 07/30/03, 07/31/03, 08/01/03, 08/04/03, 08/05/03
- Worker's Comp Services, 12/01/09, 12/14/09

Medical records from the URA include:

- xxxxxxxx, 11/23/09, 11/24/09, 12/07/09
- Official Disability Guidelines, 2008

Medical records from the Provider include:

- xxxxxxxx, 11/23/09, 12/07/09, 01/04/10

PATIENT CLINICAL HISTORY:

This gentleman was originally injured on xx/xx/xx. He was employed at that time and was pushing a machine when he had to step down from a 3-4 foot high platform. He reportedly experienced the immediate onset of low back pain with bilateral lower extremity radiation following this incident. He underwent treatment with extensive conservative therapy, including injections; however, due to continued pain ultimately surgery was performed on August 29, 2002.

The diagnoses according to a progress note dated January 8, 2003, include bilateral lumbar facet syndrome, bilateral sacroilitis, lumbar discogenic pain, and myofascial pain syndrome.

The patient has also had a mental health evaluation. This evaluation, dated June 6, 2003, indicated the patient had minimal evidence for depression on the Beck Depression Inventory, however, had severe scores on the Beck Anxiety Inventory-II. The diagnoses included adjustment disorder with mixed anxiety and depressed mood and a pain disorder associated with both psychological factors and a general medical condition.

The patient was involved in a comprehensive multi-disciplinary pain management program for eight weeks, from July 7, 2003 to August 5, 2003. This program included extensive treatment with individual psychotherapy, group therapy and comprehensive exercise, including a stretching, strengthening and conditioning program.

The patient more recently has been treated with lumbar epidural steroid injections. A second lumbar epidural steroid injection was performed on November 13, 2009.

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

I am upholding the previous adverse determination. As outlined above, the patient has had extensive past treatment with physical therapy, including involvement in a comprehensive multi-disciplinary chronic pain management program. He should be well-versed in an appropriate home exercise program, and can and should perform this home exercise program independently at this chronic stage.

The ODG Guidelines for physical therapy post lumbar epidural steroid injections support the above and indicate there is little evidence-based research that addresses the use of physical therapy post epidural steroid injections.

At most, two visits are mentioned to enforce a home exercise program. However, again in this patient's case, the individual has had extensive involvement in physical therapy, including involvement in a comprehensive multi-disciplinary chronic pain management program. He should be well-versed in an appropriate home exercise program at this time.

The ODG Guidelines, 2010 Edition, regarding physical therapy post lumbar epidural steroid injections are as follows:

Epidural Steroid Injections: Epidural steroid injections are currently recommended as a possible option for short-term treatment of radicular pain (sciatica), defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The general goal of physical therapy during the acute/subacute phase of injury is to decrease guarding, maintain motion, and decrease pain and inflammation. Progression of rehabilitation to a more advanced program of stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based research that addresses the use of physical therapy post epidural steroid injections, however, it appears that most randomized and controlled trials have utilized an ongoing, home directed program post

injection. Based on current literature, the only need for further physical therapy treatment post epidural steroid injections would be to emphasize the home exercise program, and this requirement would generally be included in the currently suggested maximum visits for the underlying condition, or at least not require more than two additional visits to reinforce the home exercise program. Epidural steroid injections have been found to have limited effectiveness for treatment of chronic pain. The patient should continue to follow a home exercise program post injection. ([Luijsterburg, 2007](#)) ([Luijsterburg2, 2007](#)) ([Price, 2005](#)) ([Vad, 2002](#)) ([Smeal, 2004](#)).

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 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)