



One Sansome Street, San Francisco, CA 94104-4448
t: 415.677.2000 f: 415.677.2193 w: lumetrasolutions.com

Notice of Independent Review Decision

DATE OF REVIEW: 7/7/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Continuation Physical Therapy 3 x wk x 4 wks – 12 visits

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

Certified by the Texas Board of Chiropractic Examiners

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
04/07/2010	001534104	Prospective	722.10	97110	Upheld
04/07/2010	001534104	Prospective	722.10	97112	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician notes dated 4/13/10, 5/24/10

Functional Capacity exam summary dated 5/24/10

Official Disability Guidelines cited but not provided-Procedure Summary, Chapter(s) Pain, Low Back Procedure Summary

PATIENT CLINICAL HISTORY:

The female sustained an injury on x/x/xx. The patient felt immediate pain to the lower back and left hip. The patient could not stand secondary to pain, was transported to a hospital and was treated with rest, cryotherapy, intravenous medication and TENS for 4 days. The patient subsequently returned home, self-treated at home without relief and sought treatment on 4/13/10. It was noted that the patient presented with complaints of severe pain, stiffness and muscle spasms affecting the lumbar spine and bilateral paraspinal areas. The patient has reportedly been treated for low back pain and sciatica within the past year, but was asymptomatic at the time of the incident. On physical examination the patient is 5' 10" and weighs 130 pounds. There is tenderness to palpation of the thoracic paravertebral musculature bilaterally T4-T12. There is tenderness to palpation of the paravertebral musculature L3-S 1. Lumbar range of motion is markedly restricted and painful in all planes. Kemp's sign was positive bilaterally. Fabere-Patrick test is positive bilaterally. Yeoman's and Nachlas' tests were positive on the left. Deep tendon reflexes were active and equal bilaterally except left Achilles which was + 1. Muscle strength of left tibialis anterior, EHL and peroneus longus was +3. Straight leg raising was positive on the left at approximately 20-30 degrees for local lumbar pain and pain into the posterolateral left thigh. Milgram's was positive bilaterally with pain at the lumbosacral and left sacroiliac region. Lumbar radiographs reportedly showed no evidence of fracture or osseous pathology. Diagnoses are lumbar disc displacement, sacroilitis, lumbar facet syndrome, lumbar sprain/strain and thoracic radiculitis.

The patient subsequently underwent 12 sessions of physical therapy. Re-examination on 5/24/10 indicates that the patient continues to complain of moderately severe to severe pain, stiffness and muscle spasms. Physical examination was unchanged with the exception of straight leg raising positive on the left at approximately 35-45 degrees. The patient reports 10% pain level improvement. The patient is reportedly medicating less frequently and sleeping better at night. MRI of the lumbar spine reportedly revealed disc herniations at L3-4, L4-5 and L5-S 1.

Functional capacity evaluation dated 5/24/10 indicates that the patient's current PDL is sedentary and required PDL is medium. Lumbar range of motion has reportedly improved from flexion 7 and extension 5 to flexion 13 and extension 11.

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

In the Reviewer's opinion, based on the clinical information provided, the request for continuation physical therapy 3 x wk x 4 wks - 12 visits is not recommended as medically necessary. The patient sustained injuries in April 2010 and subsequently completed 12 sessions of physical therapy. The submitted records indicate that physical examination was unchanged with the exception of straight leg raising positive on the left at approximately 35-45 degrees. The patient reports 10% pain level improvement. The patient is reportedly medicating less frequently and sleeping better at night. Functional capacity evaluation dated 5/24/10 indicates that the patient remains at a sedentary physical demand level, and notes that lumbar range of motion has improved from flexion 7 and extension 5 to flexion 13 and extension 11. The Official Disability

Guidelines support up to 10 visits of physical therapy for the patient's diagnosis, and there is no clear rationale or factors of delayed recovery provided to support continuing to exceed this recommendation. The patient's improvement is minimal, at best, and there is a lack of evidence of significant functional improvement secondary to physical therapy completed to date to establish the efficacy of treatment and support ongoing therapy at this time. Given the current clinical data, the requested continuation of physical therapy x 12 visits is not indicated as medically necessary.

References:

2010 Official Disability Guidelines, 15th Edition, Work Loss Data Institute, Online
Version: Low Back Chapter.

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

Medical treatment: 10 visits over 8 weeks

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

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)