

*NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION  
Workers' Compensation Health Care Non-network (WC)*

*MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 06/23/2010**

**IRO CASE #:**

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

Physical therapy 3x wk x 6wks (18 visits)

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

Texas State Licensed MD Board Certified Occupational Medicine physician

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Assignment to 06/03/2010
2. Notice of assignment to URA 06/03/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 06/01/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 05/27/2010
6. letter 05/05/2010, 04/16/2010
7. Fax auth rqst 05/28/2010, 04/28/2010, letter 04/27/2010, therapy note 04/12/2010, fax auth rqst 04/13/2010, PT order 04/08/2010, op report 07/20/2009, pre-cert rqst 07/20/2009, fax rqst 07/24/2009, letter 07/07/2009, non-auth recommendation 07/07/2009, medical note 06/30/2009, form 06/30/2009, medical note 06/24/2009, radiology report 04/23/2008
8. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

This is a man with history of chronic low back pain following a work-related incident. Based on MRI findings, the patient was diagnosed with spondylolisthesis at L4-L5 with stenosis. He underwent anterior and posterior lumbar discectomy and fusion in July of 2009. The patient's symptoms were not fully resolved and he was recommended physical therapy a couple of months ago for the relief of his condition. On his PT evaluation, the patient reported pain in his back with radiation to his left lower extremity. On examination, he was noted to have decreased range of motion with signs of radiculopathy. However, there was no clinical note of the treating doctor to substantiate the patient's findings. In addition, there was no documentation regarding the outcome of any previous post-operative physical therapy of the patient. Request is for physical therapy 3x wk x 6wks (18 visits).

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

As per ODG Guidelines: 34 physical therapy visits over 16 weeks are recommended for the post-surgical treatment (fusion) of "Displacement of thoracic or lumbar intervertebral disc without myelopathy". According to ODG: "A recent Cochrane review concluded that exercise programs starting 4-6 weeks post-surgery seem to lead to a faster decrease in pain and disability than no treatment; high intensity exercise programs seem to lead to a faster decrease in pain and

disability than low intensity programs; home exercises are as good as supervised exercises; and active programs do not increase the re-operation rate". This patient is close to one year status post lumbar fusion surgery. His last evaluation indicates that he still has pain in his back with decreased range of motion and evidence of radiculopathy. It is not clear how physical therapy would benefit him at this late post-operative stage. This patient suffers from persistent or recurrent back pain after the spinal surgery. ODG recommends that there should be interim re-evaluations noting this individual's response to care and the medical necessity for continued treatment. The medical records should include a discussion of any barriers to medical and functional improvement. An explanation and rationale for any prolonged duration of care should be documented in the provider's medical notes. No such documentation was noted in the reviewed records; therefore, the previous adverse determination is upheld.

**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
- AHCPH- 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)