

Notice of Independent Review Decision

DATE OF REVIEW: APRIL 15, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

A dispute has arisen in regards to the medical necessity of physical therapy for the examinee's lumbar and thoracic strain/sprains.

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

This reviewer is licensed by Texas Board of Chiropractic Examiners with 14 years of experience.

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

On July 7, 2009, R.N.F.N.P. evaluated the examinee. Mechanism of injury: The examinee was injured while picking up a box of canned pineapples from a table that was just above the waist level. Assessment: Thoracic strain.

On July 10, 2009, R.N.F.N.P. performed a follow-up evaluation on the examinee. Assessment: Thoracic and Lumbar strain.

On August 3, 2009, MRI of the thoracic spine was performed, read by M.D. Impression: 1. Mild multilevel thoracic spondylitic changes. No evidence of acute or subacute thoracic compression fracture. 2. 10mm lesion at T3 and 8.5 mm lesion at T10. Primary consideration for these lesions is atypical hemangioma.

On August 7, 2009, a Bone Scan was performed, read by M.D. Impression: No evidence of metastatic disease on bone scan. No abnormal activity at T3 or T10 to correspond to lesions on MRI of 8-3-09.

On August 18, 2009, Carrier filed a PLN-11 stating accepted compensable injury as thoracic/lumbar sprain only.

On August 19, 2009, M.D. evaluated the examinee. Impression: Back Strain. Recommendations: I see no reason, based on her exam or imaging studies, why she needs to be on light duty or any type of work restriction at this point. I have advised her to treat the pain symptomatically with ibuprofen 800 mg as needed. We will discharge her from routine followup at this point.

On October 21, 2009, PA-C evaluated the examinee. Assessment: Back strain. Hypertrophy on the right of the thoracic paraspinous muscle. Muscle spasms. Plan: Referral for deep tissue stimulation and compression of thoracic spine.

On November 4, 2009, M.D. performed a designated doctor examination on the examinee. placed the examinee not at MMI pending physical therapy.

On November 10, 2009, D.C. evaluated the examinee. Plan: Treatment will consist of myofascial release, electrical stimulation and heat, and prone and side posture spinal manipulation.

On March 5, 2010, M.D. evaluated the examinee. Assessment: The examinee has significant injury to the rhomboid muscle with persistent trigger points and pain. She had no improvement from injections. There are no significant interventions that would make a difference in her long-term symptoms and employability; therefore, she is at clinical MMI. assigned the examinee a 5% whole person impairment and placed the examinee at MMI as of 3/5/10.

D.C. performed physical therapy 27 sessions of physical therapy with the examinee from 11/4/09 to 1/21/09 with no improvement.

PATIENT CLINICAL HISTORY:

On xx/xx/xxxx the examinee injured her thoracic and lumbar spine while lifting a box of canned pineapples from a table to her waist level.

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

It is recommended that physical therapy should be 10 visits over eight weeks for the diagnosis of Thoracic and Lumbar strain, per the ODG- Official Disability Guidelines and Treatment Guidelines. The examinee has been treated with 27 sessions of physical therapy by D.C. from November 4, 2009 through January 21, 2009, with minimal improvement noted. On March 5, 2010, M.D. placed the examinee at maximum medical improvement. It is my professional opinion that based on the documentation provided that no further physical therapy is warranted.

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".

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):

10 visits over 5 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)**