

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 12/26/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Twelve physical therapy visits between 11/03/10 and 01/02/11

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified in Physical Medicine and Rehabilitation

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

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

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
72211	97110		Concur.	12	10/27/10 – 01/02/11				Upheld

INFORMATION PROVIDED FOR REVIEW:

1. Certificate of Independence.
2. TDI Case Assignment
3. Letters of denial 11/01/10 & 11/08/10, including criteria used in the denial (ODG).
4. S.O.A.P. notes 09/17/10 – 11/01/10.
5. Thoracic spine evaluation 09/13/10 and re-evaluation 10/15/10.
6. Physician medical record review 08/30/10.
7. Operative report 12/08/09 and follow up 12/28/09 and 01/12/10 – 02/23/10.
8. Correspondence from neurosurgeon 12/17/09 and 02/23/10.
9. Radiology reports 09/15 & 09/21/2009 and 05/06 & 09/14/2010.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This injured employee was approximately xx years of age when he underwent a left T6/T7 hemilaminectomy, medial fasciectomy, and partial transpedicular resection for a left T6/T7 discectomy on 12/08/09, following a work-related injury on xx/xx/xx. He had initially presented with axial thoracic pain with radicular component and had a fairly substantial disc herniation on the left at T6/T7 that had been managed conservatively with a combination of injections and medications. However, he continued to have significant pain. The patient was followed postoperatively, and by 02/23/10 reported being 80% better with the symptoms of left thoracic pain and radicular pain to the left anterior rib cage. He was referred to physical therapy at that time. Evidently he had extensive outpatient physical therapy, which was noted in the Peer Review documentation. The patient was referred for additional physical therapy, and he did show improvement in his symptomatology. His most recent physical therapy was completed on 10/29/10. Altogether he had approximately eleven physical therapy sessions between 09/17/10 and 10/29/10. When he was last seen on 10/29/10, his pain

level had decreased down to a 3/10, and the patient had reported increase in his strength and mobility. On his initial thoracic spine evaluation for physical therapy on 09/13/10, his pain level was 9/10. Twelve additional physical therapy sessions had been requested between 11/03/10 and 01/02/11.

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

Using the Official Disability Guidelines (ODG) Treatment for Workers' Compensation On-line Edition for neck and upper back physical therapy, this patient has shown improvement according to the documentation provided for his current physical therapy treatment. However, there is no documentation showing that this patient's frequency of treatment has been gradually decreased, nor is there any documentation showing that the patient has been transitioned over to a home exercise program. In addition, the patient has previously had extensive physical therapy for the thoracic spine after his initial thoracic surgery, which was done in December 2009. In light of all of the above, any further physical therapy for the thoracic spine is not medically indicated.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)