INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 07/07/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy for the lumbar spine-12 visits.

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

Texas Board Certified Chiropractor

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 05/21/10 – Electrodiagnostic Studies
2. 05/25/10 – MRI Lumbar Spine
3. 06/07/10 – Clinical Note –DO
4. 06/11/10 – Procedure Note
5. 07/02/10 – Procedure Note
6. 07/16/10 – Procedure Note
7. 07/26/10 – Clinical Note –DO
8. 03/04/11 – Clinical Note –DO
9. 03/21/11 – Clinical Note –MD
10. 05/05/11 – Physical Therapy Note
11. 05/24/11 – MRI Lumbar Spine
12. 06/02/11 – Physical Therapy Note

13. 06/03/11 – Utilization Review
14. 06/09/11 – Utilization Review
15. 06/10/11 – Electrodiagnostic Studies

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a male who sustained an injury on xx/xx/xx.

Electrodiagnostic studies performed 05/21/10 reveals findings suggestive of a right L5-S1 radiculopathy without denervation. MRI of the lumbar spine performed 05/25/10 reveals bilateral posterolateral protrusions at L4-5 with moderate facet arthropathy creating mild to moderate stenosis with bilateral lateral recess and foraminal encroachment. There is a right paracentral protrusion at L5-S1 with facet arthropathy creating effacement of the thecal sac with some mild right-sided foraminal encroachment. There is a right paracentral protrusion at L3-4 with facet arthropathy creating effacement of the thecal sac with some right lateral recess and inferior foraminal encroachment.

The patient underwent bilateral L4 and L5 transforaminal epidural lumbar blocks on 06/11/10, 07/02/10, and 07/16/10.

The patient saw Dr. on 03/21/11 with complaints of low back pain. Prior treatment includes physical therapy and epidural steroid injections. Physical exam reveals lumbar flexion to 35 degrees. Straight leg raise is reported to be positive on the right at 30 degrees. There is weakness of the right extensor hallucis longus, gastrocnemius, and soleus group. There is atrophy of the calf. Sensation is decreased in the right L5 and S1 dermatomes. The patient is recommended for MRI of the lumbar spine.

The patient is seen for evaluation on 05/05/11. The patient complains of low back pain rating 7 out of 10. Physical exam reveals positive Kemp's test bilaterally. There is decreased sensation of the right L5 and S1 dermatomes. There is pain to palpation at L1-5 bilaterally with a mild degree of edema noted. Lumbar range of motion testing reveals flexion to 40 degrees, extension to 10 degrees, right lateral flexion to 15 degrees, and left lateral flexion to 15 degrees with moderate to severe pain. The patient is recommended for 4 sessions of physical therapy.

MRI of the lumbar spine performed 05/25/11 reveals posterior bulging discs at L2-3, L3-4, and L4-5 with a tear in the posterior annulus fibrosus centrally at L2-3. At L5-S1, there is a posterior protrusion-subligamentous disc herniation in the central and right lateral aspect touching the thecal sac. There is a tear is in the central and right lateral aspect with hypertrophic changes seen in the facet joints. There is slight right inferior neural foraminal stenosis at this level.

The patient is seen for evaluation on 06/02/11. The patient complains of low back pain rating 5 out of 10. Physical exam reveals positive Kemp's test bilaterally. There is decreased sensation of the right L5 and S1 dermatomes. There is moderate pain to palpation of L1-5 bilaterally with a mild degree of edema noted. Lumbar range of motion

testing reveals flexion to 40 degrees, extension to 10 degrees, right lateral flexion to 15 degrees, and left lateral flexion to 15 degrees with pain. The patient is recommended for 12 sessions of physical therapy.

The request for 12 additional sessions of physical therapy is denied by utilization review on 06/03/11 as the patient has already exceeded
guideline recommendations with no evidence of functional improvement.

The request for 12 additional sessions of physical therapy is denied by utilization review on 06/09/11 lack of objective evidence demonstrating ongoing functional improvements. Electrodiagnostic studies performed 06/10/11 reveal multilevel lumbar radiculopathy involving the L4, L5, and S1 nerve roots bilaterally. There is no electrophysiological evidence of distal mononeuropathy.

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

The clinical notes indicate the patient has benefitted from prior physical therapy. It is unknown how many physical therapy sessions the patient has completed to date. Additionally, there is no evidence of functional improvement as a result of the prior physical therapy sessions. Without objective evidence of functional improvement, it is unlikely that the patient will benefit from additional physical therapy. As such, medical necessity cannot be established for Physical therapy for the lumbar spine -12 visits.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

REFERENCES:

Official Disability Guidelines, Low Back Chapter

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".

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

Medical treatment: 10 visits over 8 weeks