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Notice of Independent Review Decision

DATE OF REVIEW: 9/28/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of physical therapy 3x per week for 4 weeks lumbar (G0283, 97110, 97140, 97112).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of physical therapy 3x per week for 4 weeks lumbar (G0283, 97110, 97140, 97112).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Orthopedics and.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from 8/26/11 denial letter, 9/8/11 denial letter, 9/7/11 precert request form, 9/2/11 consult by Dr. 7/22/11 lumbar MRI report, 8/23/11

preauth request form, 8/23/11 PT progress summary, 6/17/11 to 8/22/11 lumbar flow sheets, 7/26/11 to 8/22/11 treatment encounter notes, 7/19/11 preauth request form, 6/22/11 to 7/19/11 re-eval progress notes, UR referral form not dated, 7/15/11 record ID form, 7/8/11 Spine center history report, 6/22/11 preauth request form, 5/25/11 preauth request, 5/25/11 lumbar evaluation, 5/11/11 PT script, 5/16/11 preauth request form, WC verification form, 3/9/11 to 5/11/11 reports by Dr.

Orthopedics: 5/25/11 to 8/22/11 treatment encounter notes. (all others were duplicative)

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Available medical records indicate that this worker injured his back on xx/xx/xx. He experienced immediate low back pain radiating down the right lower extremity to his foot. There was no associated bowel or bladder problem and numbness, tingling, and weakness were denied. He apparently was treated with Ativan, hydrocodone, and a cortisone injection. The medical record presented does not include records of early treatment. The first record presented for my review was dated March 9, 2011 and was from M.D. On that date, Dr. evaluation revealed weakness in the right tibialis anterior and peroneals, normal sensation, normal deep tendon reflexes, and a positive straight leg raise on the right.

An MRI of the lumbar spine was recommended as well as Meloxicam and Ultracet for symptomatic relief. When Dr. re-evaluated the injured worker on March 25, 2011, he stated that the MRI had shown a large disk herniation at L4-5, compromising almost 100% of the spinal canal. He recommended surgery. In late March, the injured worker underwent a micro discectomy. Approximately two weeks following surgery, Dr. indicated that there was 50% improvement in back and leg pain, but still continued weakness, numbness, and tingling.

On May 11, 2011, Dr. indicated that the injured worker had received good relief of symptoms for about two weeks, but then felt significantly disabled as compared to his initial postoperative status. Dr. recommended anti-inflammatory drugs and physical therapy. The injured worker subsequently underwent 23 physical therapy sessions between May 25, 2011 and August 23, 2011. A follow-up MRI of the lumbar spine performed on July 22 showed an L4-5 central and left paracentral disk protrusion, mild central canal stenosis, moderate bilateral neural foraminal narrowing, and post-surgical changes of a partial right laminotomy and L4-5 discectomy.

The injured worker was last evaluated by physical therapy on August 23, 2011. At that time, he was continuing to experience pain with lifting and prolonged standing. Flexibility was improving, but was still limited. Range of motion was described as "75%." It was stated that the injured worker was continuing to

progress with work related activity, but still did not meet the job requirements for return to work. The physical therapist recommended more physical therapy three times a week for four weeks, but stated that if this was not approved, a functional capacity evaluation and work conditioning program would be indicated.

Utilization review processes were performed by M.D. on August 26, 2011 and by M.D. on September 8, 2011. Both of these reviewers recommended denial of the requested continued therapy because the therapy exceeds ODG Guidelines and there was no explanation for why the patient was experiencing exceptional problems that would require continued therapy.

On September 2, 2011, M.D., a pain management specialist, evaluated the injured worker. He stated that a micro discectomy had helped "60%" and stated that physical therapy, bracing, and medications had given some relief. His assessment was that the injured worker had a post laminectomy syndrome at L4-5 with recurrent herniation, a lumbar radiculopathy, and a lumbar sprain. He recommended a transforaminal bilateral L4, L5 epidural steroid injection.

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

This worker was injured on xx/xx/xx at work. He developed a large disk herniation at L4-5 compromising almost 100% of the spinal canal. He underwent a lumbar laminectomy and discectomy in late March. He began physical therapy approximately two months later and had a total of 23 physical therapy sessions. MRI scanning of the lumbar spine showed continuing problems at the L4-5 level and epidural steroid injections were recommended by a pain management specialist. The physical therapist also recommended physical therapy or work conditioning.

ODG Guidelines state that "as compared to no therapy, physical therapy (up to 20 sessions over 12 weeks) following disk herniation surgery was effective." The Guides further state that "a recent Cochrane review concluded that home exercises are as good as supervised exercises." The ODG Treatment Guidelines suggest post-surgical physical therapy treatment following discectomy and laminectomy including 16 visits over eight weeks. The Guides further state that "when treatment duration and/or number of visits exceed the Guidelines, exceptional factors should be noted."

At this point, this injured worker has received 23 post-operative sessions. He continues to have pain and limited lifting tolerance. He had already exceeded the recommended post-surgical physical therapy treatment sessions recommended by the Guidelines. Assuming that he has been treated according to guidelines, he should be well instructed in a home exercise and treatment plan. There is no clear indication or reason for the need for continuing physical therapy as prescribed. Work conditioning and epidural steroid injections have

been recommended, but these are different procedures from the physical therapy requested. This medical record does not support the prospective medical necessity of physical therapy three times a week for four more weeks. Therefore, the requested services are found to be not medically necessary at this time.

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)