



Notice of Independent Review Decision

DATE OF REVIEW: 10/03/11

DATE OF AMENDED REVIEW: 10/04/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy Lumbar Spine x 12 Sessions; 4 Units per Session
Myofascial Release Lumbar Spine x 12 Sessions; 1 Unit per Session
Electric Stimulation Lumbar Spine x 12 Sessions; 1 Unit per Session
Joint Mobilization Lumbar Spine x 12 Sessions; 1 Unit per Session

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

Board Certified in Physical Medicine & Rehabilitation

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.

Physical Therapy Lumbar Spine x 12 Sessions; 4 Units per Session – OVERTURNED
Myofascial Release Lumbar Spine x 12 Sessions; 1 Unit per Session – OVERTURNED
Electric Stimulation Lumbar Spine x 12 Sessions; 1 Unit per Session – OVERTURNED
Joint Mobilization Lumbar Spine x 12 Sessions; 1 Unit per Session – OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Employer's First Report of Injury or Illness, xx/xx/xx
- Associate Statement, xx/xx/xx
- Offer, xx/xx/xx, 09/14/10, 09/22/10
- Evaluation, M.D.,xx/xx/xx , 09/13/10, 09/14/10, 09/21/10
- DWC Form 73, Dr.xx/xx/xx, 09/14/10, 09/21/10
- Lumbar Spine MRI, Care System, 09/13/10
- Medical Screening, 09/13/10
- DWC Form 73, M.D., 09/13/10
- Initial Evaluation, Physical Therapy, 09/16/10
- Right Lower Extremity MRI, M.D., 09/30/10
- Evaluation, M.D., 10/01/10, 11/05/10, 02/18/11, 03/22/11
- Physical Medicine/Rehabilitation Plan, 10/01/10
- DWC Form 73, Healthcare Systems, 10/01/10, 11/05/10
- Notice of Disputed Issue(s) and Refusal to Pay Benefits, 10/08/10
- Functional Capacity Evaluation (FCE), Healthcare Systems, 10/11/10
- Designated Doctor Examination (DDE), M.D., 01/24/11
- Subjective Re-Evaluation, 02/16/11, 03/22/11
- Electrodiagnostic Studies, M.D., 03/14/11
- Nurse Review Report, R.N., B.S.N., L.N.C., 06/24/11
- Initial Evaluation, M.D., 07/19/11
- DWC Form 73, Dr., 07/19/11
- Denial Letters, , 08/02/11, 08/24/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The records available for review document that the date of injury is listed as xx/xx/xx. On the date of injury, the patient slipped on a wet surface and sustained a fall.

A lumbar MRI was accomplished on 09/13/10. This study was described as "essentially negative lumbar spine MRI."

The patient received an evaluation at Physical Therapy on 09/16/10 at which time the patient was with symptoms of low back pain. There were no documented radicular symptoms.

An MRI of the right knee was accomplished on 09/30/10. This study showed findings consistent with a minimum amount of edema in the Hoffa's fat pad on the inferior lateral margin of the patella. There was evidence of a minimal joint effusion.

The patient was evaluated by Dr. on 10/01/10. On that date, she was with symptoms of low back pain and right knee pain. There were no documented motor deficits on physical

examination. She was diagnosed with a lumbar strain, as well as a right knee contusion. It was recommended that the patient receive access to treatment in the form of physical therapy services.

Dr. reassessed the patient on 11/05/10. It was documented that physical therapy was not pursued because the patient was with symptoms of pain in the affected body regions. A Functional Capacity Evaluation (FCE) was accomplished. It was documented that physical therapy was subsequently denied. The FCE, per the office note of 11/05/10, indicated "significant impairment." The official FCE report is not available for review.

A Designated Doctor Evaluation (DDE) was conducted by Dr. on 01/24/11. On this date, the patient was not placed at the level of Maximum Medical Improvement (MMI). It was anticipated that MMI would be reached by 04/24/10.

Dr. evaluated the claimant on 02/18/11. It was recommended that an electrodiagnostic assessment of the lower extremities be accomplished as the claimant was with symptoms of pain in the right lower extremity.

An electrodiagnostic assessment was obtained on 03/14/11. No neurological deficits were noted on physical examination. The study revealed findings suggestive, but not diagnostic, of a right L5 radiculopathy.

Dr. evaluated the patient on 03/02/11. It was recommended that a repeat lumbar MRI be accomplished.

The patient was evaluated by Dr. on 07/19/11. On this date, it was recommended that a repeat lumbar MRI be accomplished. The patient was provided a prescription for treatment in the form of twelve sessions of physical therapy, and a prescription for Fioricet, a prescription for Mobic, a prescription for Flexeril, as well as a prescription for Thera-Gesic analgesic cream.

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

Based upon the records available for review, the primary medical condition referable to the patient's work injury of xx/xx/xx would appear to be the following: a) a lumbar strain and b) a right knee contusion. These medical conditions in and of themselves are generally considered to be self-limiting in nature. The records available for review do not document the presence of any neurological deficit on physical examination. It would appear that a neuro-diagnostic assessment has been completed in the form of a lumbar MRI, as well as an MRI of the right knee. The results of these diagnostic studies are as described above. The records available for review do not provide any documentation to indicate that previous treatment has included an attempt at treatment in the form of physical therapy services. For a medical condition of a muscular strain/contusion to an affected body region, in this particular case, the Official Disability Guidelines would

support twelve sessions of supervised physical therapy services provided that physical therapy services include patient education on a proper non-supervised rehabilitation regimen. As stated above, a medical condition of a muscular strain/contusion is a medical condition which would generally be considered to be self-limiting in nature. As such, the Official Disability Guidelines would support an expectation that an individual should be capable of performing a proper nonsupervisory rehabilitation regimen upon completion of twelve sessions of physical therapy services. Hence, based upon the records available for review, the above noted reference would support an attempt at twelve sessions of physical therapy services for the described medical situation.

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)**
- AMA GUIDES 5TH EDITION**