

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** FEBRUARY 14, 2012

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of the proposed 6 additional sessions of physical therapy ( 97002, 97110, 97112, 97140, 97530)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

### **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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
847.2	97002		Prosp	6					Upheld
728.85	97110		Prosp	6					Upheld
E927.0	97112		Prosp	6					Upheld
847.2	97140		Prosp	6					Upheld
847.2	97530		Prosp	6					Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-18 pages

Respondent records- a total of 41 pages of records received to include but not limited to: TDI letter 1.24.12; Advanced Physical Therapy notes 11.8.11-11.17.11, note 1.3.12; Orthopedics and Sports Medicine notes 11.28.11; letters 1.6.12, 1.13.12; request for an IRO forms; RME report 1.11.12

Requestor records- a total of 41 pages of records received to include but not limited to: request for an IRO forms ; TDI letter 1.24.12; Advanced Physical Therapy notes 10.11.11-11.17.11, note 1.3.12; Orthopedics and Sports Medicine notes 8.23.11-1.9.12; records DO notes 9.2.11-10.19.11; letters 10.31.11; MRI Lumbar spine 6.1.11

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The medical records presented for review begin with the initial orthopedic consultation completed on August 23, 2011. Dr. noted that the injured individual sustained a low back injury while moving boxes dating back to xx/xx/xx. It was reported that the claimant squatted down, felt terrible pain in her low back, and was seen at the facility. The physical examination noted the claimant to be 5'3" and 144 pounds. There were no motor deficits, no sensory deficits, the claimant had a negative straight leg raise; however, there was tenderness to palpation noted. An MRI reportedly demonstrated multiple level degenerative disease without any significant nerve root encroachment. There were signs of significant left leg radiculopathy reported, but no real findings noted on the MRI to support that assessment. Electrodiagnostic testing was sought.

At a follow-up visit the claimant was noted to have ongoing low back pain. The electrodiagnostic assessment reportedly revealed no evidence of radicular symptoms. The assessment became sacroiliitis as there was a positive Faber and Gaenslen maneuver. A pain management referral was made. Dr. completed his evaluation and made an assessment of degenerative disc disease and low back pain.

A medial branch block at L3, L4, and L5 was completed. 80% relief of low back pain was noted. A medial branch radiofrequency neurotomy was completed on November 16, 2011. It was reported that this procedure achieved 40% relief of pain. The records indicate that some physical therapy had been completed; however, the progress notes were not clear how much had been completed. The physical therapy notes seem to indicate that 11 sessions were delivered to the claimant. A repeat electrodiagnostic assessment was completed and no significant findings were reported.

The MRI dated June 1, 2011, noted no evidence of significant disc bulge from T 12 through L3. There were diffuse 2 millimeter changes at L3/4, L4/5, and L5/S1, no evidence of any significant bulk. Facet hypertrophy was noted at multiple levels. There is no spinal stenosis identified.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

#### **RATIONALE:**

**As noted in the Division mandated Official Disability Guidelines physical therapy is warranted to a degree. Specifically, 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

**Sprains and strains of sacroiliac region (ICD9 846):**

Medical treatment: 10 visits over 8 weeks

**Lumbago; Backache, unspecified (ICD9 724.2; 724.5):**

9 visits over 8 weeks

In that the amount of physical therapy that had been delivered exceeded the noted amounts, and that there is no objectified functional gain from these interventions, tempered with the notion that the medial branch blocks and rhizotomy only obtained 40% relief, there is no competent, objective and independently confirmable medical evidence presented to support continuing additional physical therapy in this case.

**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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)