MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
1225 North Loop West ● Suite 1055 ● Houston, TX 77008
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: **December 19, 2013**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Six sessions of physical therapy to the lower back at Physical Therapy

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

This case was reviewed by a physician board certified in Physical Medicine and Rehabilitation currently licensed and practicing in the state of Texas.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a male who injured his lower back on xx/xx/xx. He was seen on 11/07/2012 with chief complaint of lower back pain without radiating pain to legs. On physical exam, there was no muscle guarding, SLR negative at 80 degrees bilaterally, good alignment, no atrophy, no sensory deficits, and reflexes were 1+ and symmetrical bilaterally. diagnosed him with lumbar sprain, with 3-4 mm of anterior slip of L4 on L5, recurrence of lower back pain. He recommended return to work with restrictions and requested FCE. There is a request for 6 sessions of physical therapy dated 08/30/2013. He completed 12 sessions of physical therapy from 09/05/2013 to 10/28/2013. A physical therapy note dated 10/28/2013 indicates his pain level of 1/10 for last 3 days but gets increased pain after 4 hours of work. On physical exam, AROM of lumbar spine was flexion 20, Extension WNL, Right side bending 46.1, Left side bending 49.7, Right rotation, 79, and Left rotation 75. Strength was 5/5. Plan was to continue with HEP unless pain increases. Records indicate that xxxx xxxxx has completed 24 sessions of physical therapy since the date of injury.

MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
1225 North Loop West ● Suite 1055 ● Houston, TX 77008
800-845-8982 FAX: 713-583-5943

There is a request dated 11/11/2013 for additional 6 sessions of physical therapy to lower back.

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

The patient has per available records already completed 24 sessions of physical therapy since the date of injury. Based on physical therapy notes the patient's pain levels average 1/10 but increase after four hours of work. His lumbar range of motion and motor testing was reported as within normal limits. A home exercise program is the correct plan of action at this time as a formal physical therapy program is unlikely to result in significant improvement in functional capabilities.

ODG guidelines are as follows: 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

The patient has clearly exceeded all ODG guidelines and as such is not appropriate for further PT treatments.

ODG Physical Therapy Guidelines – (Lower Back)
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
Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):
Medical treatment: 10 visits over 8 weeks

MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
1225 North Loop West ● Suite 1055 ● Houston, TX 77008
800-845-8982 FAX: 713-583-5943

Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks
Post-surgical treatment (arthroplasty): 26 visits over 16 weeks
Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks
Intervertebral disc disorder with myelopathy (ICD9 722.7)
Medical treatment: 10 visits over 8 weeks
Post-surgical treatment: 48 visits over 18 weeks
Spinal stenosis (ICD9 724.0):
10 visits over 8 weeks
See 722.1 for post-surgical visits
Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):
10-12 visits over 8 weeks
See 722.1 for post-surgical visits
Curvature of spine (ICD9 737)
12 visits over 10 weeks
See 722.1 for post-surgical visits
Fracture of vertebral column without spinal cord injury (ICD9 805):
Medical treatment: 8 visits over 10 weeks
Post-surgical treatment: 34 visits over 16 weeks
Fracture of vertebral column with spinal cord injury (ICD9 806):
Medical treatment: 8 visits over 10 weeks
Post-surgical treatment: 48 visits over 18 weeks
Work conditioning (See also Procedure Summary entry):
10 visits over 8 weeks

MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
1225 North Loop West ● Suite 1055 ● Houston, TX 77008
800-845-8982 FAX: 713-583-5943

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

X 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)