



CompPartners Final Report



CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name:

Texas IRO # :

MDR #: M2-06-1703-01

Social Security #: XXX-XX-

Treating Provider: Arnulfo Carrasco, MD

Review: Chart

State: TX

Date Completed: 8/30/06

Review Data:

- **Notification of IRO Assignment dated 8/8/06, 1 page.**
- **Receipt of Request dated 8/8/06, 1 page.**
- **Medical Dispute Resolution Request/Response dated 6/28/06, 2 pages.**
- **Table of Disputed Services (date unspecified), 1 page.**
- **List of Treating Providers (date unspecified), 1 page.**
- **Pre-Authorization Request dated 5/23/06, 1 page.**
- **Prescription dated 5/18/06, 1 page.**
- **Letter dated 6/21/06, 6/7/06, 4 pages.**
- **Follow-up Examination dated 5/18/06, 3/23/06, 2/9/06, 1/3/06, 11/22/05, 5 pages.**
- **Initial Consultation dated 10/14/05, 2 pages.**
- **Operative Report dated 6/15/06, 1/19/06, 12/22/05, 12/8/05, 10/27/05, 5 pages.**
- **Lumbar Spine MRI dated 11/15/05, 1 page.**

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for physical therapy to include CPT codes 97110, 97112, 97116, 97140, 97530 and G0283.

Determination: UPHELD - the previously denied request for physical therapy to include CPT codes 97110, 97112, 97116, 97140, 97530 and G0283.

Rationale:

Patient's age: 45 years

Gender: Female

Date of Injury: ____

Mechanism of Injury: Twisting movement while squatting and developed sharp stabbing pain to the low back and buttock.

Diagnoses: Lumbar degenerative disc disease.
Low back pain, with lumbar radiculopathy.
Facet arthropathy.
Myofascial pain syndrome.

The claimant was diagnosed with lumbar degenerative disc disease, low back pain with lumbar radiculopathy, facet arthropathy and myofascial pain syndrome. Over the past thirteen months post injury, the claimant underwent extensive conservative treatment, including physical therapy, medications, epidural steroid injections, trigger point injections, Botox injections and a home exercise and stretching program. Physical therapy, three times per week for four weeks, was requested. Based upon the provided information, physical therapy, three times per week for four weeks, is not recommended as medically necessary at this time. This claimant has had well over one year of conservative treatment. Dr. Carrasco's initial evaluation of the claimant on 10/14/05, noted that the physical therapy sessions already attended had provided no relief. Significant improvement was reported following a series of three lumbar epidural steroid injections. No objective clinical information, including functional deficits or limitations of strength or range of motion, had been documented in 3 months. The claimant has had prior physical therapy that would have provided instruction in a home exercise program. There was no evidence presented in the records reviewed that would indicate that the claimant is incapable of performing her home program independently. Self motivation and management are important to overall recovery. Passive modalities are neither curative nor restorative, and most can be performed at home. Generally, the licensed physical therapist is needed only for one or two visits for education and instruction for long term independent exercise programs. Based on the records reviewed, there was no documentation to support that formal palliative therapy would lead to significant improvement in this claimant's condition. Therefore, physical therapy, three times per week for four weeks, is not recommended as medically necessary.

Criteria/Guidelines utilized: TDI/DWC Rules and Regulations.

Ingenix Encoder Pro 4.3.

ACOEM Guidelines, 2nd Edition, Chapters 6 and 12.

Physical Medicine & Rehabilitation, 2nd Edition, Braddom R.L., "Low Back Pain and Disorders of the Lumbar Spine", Chapter 40, pp. 853-893.

Clinical Orthopedic Rehabilitation, 2nd Edition, Brotzman & Wilk, Chapter 9: "Low Back Injuries", pp. 555-601

Physician Reviewers Specialty: Orthopedic Surgeon

Physician Reviewers Qualifications: Texas licensed M.D. and is also currently listed on the TDI/DWC ADL list.

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CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.

Your Right to Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

In accordance with Division Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, requestor, claimant and the Division via facsimile or U.S. Postal Service from the office of the IRO on this 30th day of August, 2006.

Signature of IRO Employee:

Printed Name of IRO Employee
LeeAnne Strang
Senior PRN Supervisor
CompPartners

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