

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 8/8/2007
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy 3 times a week for 4 weeks

QUALIFICATIONS OF THE REVIEWER:

This reviewer obtained his Doctor of Medicine from the state University of New York Health Science Center at the Brooklyn College of Medicine in Brooklyn, New York. He also obtained a Master of Public Health from the Harvard School of Public Health in Boston, Massachusetts. He is a member of the International Spinal Cord Society, the American Medical Association, and the American Academy of PM&R. He has had numerous peer reviewed publications and is licensed in the states of New York and Massachusetts.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

Physical therapy 3 times a week for 4 weeks Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical note dated 07/03/2007
2. Clinical note by RN dated 05/17/2007
3. Request form dated 05/09/2007
4. Review organization IRO dated 08/07/2007
5. providers dated 08/07/2007
6. URA providers note dated 08/07/2007
7. Clinical note dated 04/25/2007
8. Clinical note dated 05/15/2007
9. Clinical note by RN dated 07/02/2007
10. Review of case assignment note dated 07/03/2007
11. Clinical note dated 07/05/2007
12. Position statement note by RN dated 07/05/2007
13. Clinical note dated 04/25/2007
14. Clinical note dated 05/15/2007
15. Peer review report dated 04/25/2007
16. Peer review report by DO dated 05/14/2007

Name: Patient_Name

17. Status report dated 04/23/2007
18. Re-Authorization request form dated 08/07/2007
19. Occupational therapy prescription note by MD dated 04/23/2007
20. Description note dated 04/23/2007

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This injured employee was noted to have an exacerbation of a prior low back injury which occurred. He has had 26 sessions of physical therapy, lumbar ESI's x3, and NSAID's. The injured employee noted improvement in range of motion and pain relief. Impression was low back pain with radiculopathy. A note dated 4/23/2007 reported increased back pain. Additional physical therapy 3 times a week for 4 weeks is under review.

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

The focus of previous physical therapy has been passive modalities including moist heat, ice packs, ultrasound, electrical stimulation, myofascial release, as well as basic exercises such as core strengthening, stretching, flexibility, and other exercises that should no longer require skilled physical therapy educational or supervisory services given his prior therapy sessions. It is unclear what specific impairments or disabilities are being addressed, and there are presently no specific functional goals stated or identifiable at this point that would warrant further supervised outpatient physical therapy. The patient has had an exacerbation of a chronic benign mechanical pain that will have a natural history of intermittent exacerbations and fluctuating symptomatology. No marginal benefit with respect to long term outcomes or functional status, however, can be anticipated with further supervised outpatient therapy above that which would be achieved by a program of pharmaceutical management, self-applied modalities, and a committed self-directed exercise program. The continuation of supervised basic exercise and passive modalities such as ultrasound, electrical stimulation, and myofascial release is not medically necessary, given a lack of proven sustained benefit of these services on net healthcare outcomes in mechanical back pain. Therefore, the proposed extension of services cannot be certified as medically necessary. Transition to a self-directed program is recommended. The previous denial is upheld.

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)