Advanced Medical Reviews

ACCREDITED
EXTERNAL REVIEW

DATE OF REVIEW: 6/11/2007
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy 3 times a week for 5 weeks (97530, 97112, 97035, 97110, 97140).

QULIFICATIONS OF THE REVIEWER:

This reviewer obtained his Doctor of Medicine from the state. He also obtained a Master. He is a member. He has had numerous peer reviewed publications and is licensed.

REVIEW OUTCOME:

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

X	Upheld	(Agree)
	Overturned	(Disagree)
	Partially Overturned	(Agree in part/Disagree in part)

Physical therapy 3 times a week for 5 weeks (97530, 97112, 97035, 97110, 97140). Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical note dated 05/23/2007
2. Review organization note by dated 03/23/2007
3. Clinical note by dated 03/27/2007
4. Lumbar spine note by MD dated 05/14/2007
5. NCS report by MD dated 05/08/2007
6. Clinical note by MD dated 05/08/2007
7. Clinical note by dated 03/27/2007
8. Clinical note by dated 05/07/2007
9. Clinical note dated 05/21/2007
10. Authorization recommendation note by MD dated 05/11/2007
11. Compensation note dated 06/04/2007
12. Non authorization note by RN dated 05/19/2007
13. Compensation note dated 06/04/2007
14. Clinical note dated 05/21/2007
15. Review organization note dated 05/21/2007
16. Review organization note dated 05/21/2007
17. Case assignment note by dated 05/23/2007
18. Clinical note dated 05/23/2007
19. Review organization note by dated 05/23/2007
20. Clinical note dated 04/04/2007
21. Clinical note by dated 05/27/2007
22. Clinical note dated 05/14/2007
23. Clinical note by dated 05/07/2007
24. Authorization recommendation note by RN dated 05/11/2007
25. Compensation note dated 06/04/2007
26. Clinical note dated 06/04/2007
27. Non authorization note by RN dated 05/19/2007

28. Compensation note dated 06/04/2007
29. Clinical note dated 06/04/2007
30. Clinical note dated 05/21/2007
31. Review organization note dated 03/21/2007
32. Authorization recommendation note by RN dated 05/11/2007
33. Non authorization note by RN dated 05/19/2007
34. Clinical note dated 05/21/2007

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This male was injured while working as a welder/laborer on xx/xx/xx. At that time he was manually lifting and maneuvering a large pipe that weighed approximately 60 pounds when he felt a sharp pull across his lower back and hip regions. He described the lumbar spine injury as sharp and stabbing pain which radiated into his right and left hip and right lower extremity. The injured worker stated that he had not experienced any of those symptoms prior to the work incident.

A MRI of the lumbar spine on 5/14/2007 revealed a foraminal disc herniation at L5-S1 with impinges upon the L5 nerve root within the right foramen. There was also a central protrusion without spinal canal stenosis and facet degeneration at L4-5.

The conclusions of an electromyographical study were bilateral L5-S1 lumbar radiculopathy, clinical right SI dysfunction, and no NCV evidence of peripheral neuropathy, plexopathy, or entrapments.

At this time, the request for physical therapy 3 times a week for 5 weeks is under review.

97530 - Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

97112 - Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

97035 - Application of a modality to one or more areas; ultrasound, each 15 minutes

97110 - Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

97140 - Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

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

Although the injured worker apparently had suboptimal pain control and range of motion, there were no clear functional goals stated or identifiable during the period under review that would warrant additional supervised outpatient physical therapy beyond that which was approved initially. In particular, based on the records available for review, the nature of the therapies rendered to date, as well as the type of exercises and therapies for the 15 additionally proposed sessions are unclear. No therapies of proven sustained benefit on net healthcare outcomes in the setting of radiculopathy have been proposed. It is not clear why the worker has not been fully transitioned to a self-directed exercise program at this time. No marginal benefit in relation to sustained analgesic relief or functional gains are anticipated with further supervised outpatient therapy above that which would be achieved by conservative therapy including pharmaceutical management, self-applied modalities, and a committed self-directed exercise program. If there are complex biomechanical issues requiring prolonged skilled services, these have not been documented. From a medical standpoint, there is no objective evidence that the additional therapy sessions are medically necessary or warranted. Therefore, certification of the 15 additionally proposed therapy sessions under review cannot be given at the present time given the standards of evidence-based medicine and the documents made available for review. Accordingly, the previous denial is upheld.

Name: Patient_Name

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)