



DATE OF REVIEW: 5/3/2007
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

- 1. 8 sessions of physical therapy.

QUALIFICATIONS OF THE REVIEWER:

This reviewer attended University before graduating from the College of Chiropractic in 1989. He has been in private practice in San Diego County for over 14 years. He also works as a team chiropractor for a local high school. He has also worked as a peer reviewer doing Worker’s Compensation and Personal Injury Prospective, Retrospective, Forensic, and Chart Reviews since 10/2000. His post graduate studies include various seminars on cervical spine “whiplash” syndrome, arthritis, neurology, radiology, sports medicine, and worker’s compensation.

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)

- 1. 8 sessions of physical therapy. Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 1. Clinical note dated 04/06/2007
- 2. medical reviews dated 04/04/2007
- 3. Independent review dated 04/02/2007
- 4. Company request form IRO dated 03/10/2007
- 5. Organization note dated 02/27/2007
- 6. Clinical note by, X dated 02/23/2007
- 7. Clinical note by RN dated 03/08/2007

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The patient was noted to be a male who developed low back pain after lifting a patient. The claimant has received 10-12 sessions of physical therapy and this is a request for 8 additional sessions. A prior request for additional physical therapy was denied as it was deemed the patient could perform home exercises.

The request for 8 additional physical therapy sessions is under review.

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

The claimant is a male who was involved in a work injury. The injury was described as the claimant was lifting a patient from the chair to a bed resulting in lower back pain. The claimant what was initially evaluated at medical center.

Name: Patient_Name

On 1/15/2007 the claimant changed treating doctors and presented to the office of Dr., D.C. A course of physical therapy was initiated. The claimant received a total of 22 treatments.

An MRI of the lumbar spine dated 2/5/2007 revealed a focal posterocentral 2 mm disc protrusion at L5-S1 in addition to facet hypertrophy bilaterally at L3-4 and L5-S1 bilaterally.

On 2/8/2007 the claimant was evaluated by Dr., neurologist. This report indicated that the claimant had a significant past history of epilepsy. The recommendation was for anti-inflammatory medication.

On 2/15/2007 a functional capacity evaluation was performed. The result was that the claimant was giving a submaximal effort. There was considerable pain during activities without an increase in heart rate, as would be anticipated.

A request for eight additional physical therapy sessions was submitted. This was initially denied by peer review on 2/23/2007. On 3/8/2007 the request went to appeal and was again denied. The purpose of this independent review is to determine the necessity for the requested eight additional sessions of physical therapy.

The medical necessity for the requested the additional treatments was not established.

At the time of this request the claimant had received 13 physical therapy treatments. At that time the claimant's pain levels were noted to be 4 out of 10 on the visual analogue scale. There was no reexamination performed at that time supporting improvement in the claimant's condition. Moreover, the previous peer review dated 3/23/2007 indicated that the peer reviewer had a case discussion with the AP. There was a discrepancy suggesting that Dr. was basing his treatment recommendations based on an unrelated epilepsy condition. Given the claimant's presenting complaints, absence of document improvement, and the absence of maximal effort on the 2/15/2007 functional capacity evaluation, the medical necessity for 8 additional physical therapy sessions was not established.

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

X 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)

MILLIMAN CARE GUIDELINES

Spine (Rehabilitation, Orthopedic)

Low Back Pain and Lumbar Spine Conditions

ODG Physical Therapy Guidelines

AMR Tracking Num: