

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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DATE OF REVIEW: SEPTEMBER 7, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical rehabilitation twice a week for three weeks to include 97139 (Unlisted therapeutic procedure), 97110 (Therapeutic procedure), 97112 (Neuromuscular re-education), 97140 (Manual therapy techniques, G0283 (Electrical stimulation unattended).

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

MD, Board Certified in Physical Medicine and Rehabilitation

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- * Group denial letter dated 7/12/07, 7/27/07.
- * Rehabilitation [3/5/07, 2/26/07, 2/23/07, 2/19/07, 2/14/07, 2/13/07]
- * Institute documentation [6/5/07, 7/5/07, 7/6/07, 7/12/07, 7/16/07, 7/23/07]
- * Review [7/12/07]; Appeal [7/20/07]

PATIENT CLINICAL HISTORY [SUMMARY]:

Dr. letter states this is a xx-year-old patient with pain in the lower back and lower extremities from an on-the-job injury. He has gone to state that she is being denied further care as well as being denied

payment of previous services in excess of \$10,000. On a letter dated July 16, 2007, Dr. indicates the patient is being denied rehabilitation two times a week for three weeks and two lumbar epidural steroid injections under fluoroscopic control and four to six trigger injections. He indicates previous similar injections in the past have given her up to nine months of relief. Also indicates MRI from February 2006 shows an annular bulge at L2-L3, diffuse ligamentum flavum, facet hypertrophy, and mild-to-moderate central canal narrowing. He reports neuroforaminal narrowing at L3-L4 and L4-L5 with asymmetrical annular bulge causing right-greater-than-left lateral recess narrowing. His note dated To Whom It May Concern indicates the pain is worse on the left than the right. Records from a medical institute of America dated July 12, 2007 are reviewed. Reason for denial based on that letter is that patient had therapy in 2007 in February and has also been in most recent letter of June 2007 stated to be a surgical candidate and therapy does not appear to be appropriate at this point in time in review of these needs. Earlier prescription by Dr. dated July 5, 2007 indicating therapy two times a week for three weeks asking for moist heat, electrical stem, strengthening exercises, stretching exercises, neuromuscular reeducation, myofascial release, and manual therapy.

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

After reviewing records provided for this case, it seems to be medically unwarranted and not supported by the documents provided that physical therapy for soft tissue, myofascial release, and massage could be an appropriate treatment for an injury that occurred at the low back in 1999, especially in a patient that has received extensive treatment prior to this including prior injections and physical therapy as recently as six months prior. There is no way to ascertain that her current pain complaints of the soft tissues have any relationship whatever to the 1999 injury presently, and secondly there is no medical evidence to indicate that soft tissue myofascial release every six months will aide the patient reducing her pain and spasm and certainly a patient with this long history of injury should be well versed in home stretching and exercises. Guidelines utilized for denial include ODG guideline for lumbosacral spine pain.

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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
- 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)