



Specialty Independent Review Organization

## Notice of Independent Review Decision

**DATE OF REVIEW:** 8/28/08

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The services under dispute include active rehab therapy (97110), three times per week for three weeks.

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

The reviewer is a Doctor of Chiropractic with greater than 10 years of experience.

### **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)

The reviewer agrees with the previous determination regarding all its parts.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

These records consist of the following: (all records are listed from one party only to avoid duplication) 8/13/08 letter 8/12/08 letter, E1 report of 6/10/08, various DWC 73's, 6/16/08 notes from covenant hospital, 6/16/08 through 7/18/08 SOAP

notes by Dr, 6/17/08 report by Dr., 6/24/08 FCE, 6/9/08 PT request, 7/2/08 email, 7/3/08 MRI lumbar, 7/18/08 denial report and 7/31/08 denial report.

Dr. 6/10/08 initial report, interim eval of 7/15/08, 7/30/08 letter by Dr. and 7/18/08 through 7/21/08 SOAP notes by Dr.

Company: no additional info not previously mentioned.

We did not receive a copy of the WC Network Treatment Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured on xx/xx/xx while employed. The history indicates she was carrying book bags filled with books approximately 30 feet when she felt lower back pain. She measures 5'4" and weighs 140 lbs according to the records. Initially, grade 4 weakness was found in the left LE and LSR was positive at 50 degrees. The initial diagnosis is that of lumbar sprain and radiculitis.

A later exam in July of 2008 indicates increased lumbar flexion, decreased lumbar extension and increased lateral flexion. Gastrocnemius strength had returned to normal while hamstring strength was still rated at a 4/5. An MRI indicated annular tearing and bulging at L4/5 and L5/S1. L4 nerve displacement was also noted.

She has been treated conservatively with passive modalities and active therapies. Her initial pain scale is a 5/10 while her most recent SOAP notes indicate a pain scale of 2 at rest and a 4/10 while working.

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

According to the ODG, the treatment protocol for an intervertebral disc disorder without myelopathy is as follows:

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion): 34 visits over 16 weeks

The reviewer indicates that the request is outside of the bounds of the ODG as it exceeds normative data. Secondly, the reviewer indicates that the documentation of the rehabilitative encounters is less than the standard. Generally speaking the documentation consists of a few numbers (sets, reps and weights) without additional info regarding patient response to said treatment. Lastly, the patient

has improved with care but it cannot be shown with the lack of reliable documentation of the active rehab program that this is the treatment that is making the difference.

**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)**