



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 6/30/08

IRO CASE #:

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

The reviewer is a Doctor of Chiropractic who is Board Certified in Rehabilitation and has been practicing greater than 10 years.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include PT codes 97110, 97112 and 97140 3 times per week for four weeks (12 total sessions).

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 adverse determination regarding all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Dr. and Healthcare.

These records consist of the following (duplicate records are only listed from one source): Dr.: Initial physical exam (4/10/08) DC, 4/22/08 to 4/29/08 reports by, MD, 4/16/08 neurodiagnostic exam, 3/5/08 report by, MD, report by, MD 4/21/08, 9/12/07 lumbar and right hip MRI, FCE 4/16/08, DWC 53 of 4/1/08, notes from 9/4/07 to 1/31/08, 1/4/08 DD report by DO and various DWC 73's.

: 4/18/08 denial letter, 4/25/08 denial letter, 4/29/08 ESI procedure report, 4/23/08 request for treatment by, reports by, MD 5/27/08, note by 5/13/08, preauth request for MRI by MRI, script by Dr. for MRI, 3/8/08 report by, MD, appeal letter

of 4/22/08, 12/5/07 notice of dispute by, 12/14/07 report by MD (missing first page) and 1/31/08 report by MD.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured in xx/xx. A previous history of diabetes and lumbar surgery is noted. An MRI in March 2008 reveals fusion at L5/S1 with posterior spondylosis which contacts but does not displace the S1 nerve root on the right. Foraminal narrowing is present with bilateral interfacetal fusion at L3/4 and L4/5. The DD did not place him at MMI in January of 2008

An FCE in April indicates a sedentary PDL. The initial exam notes a pain scale of 8/10 and the same reflex designations as the 5/13/08 examination. Dr. note of 5/13/08 indicates a 0/5 reflex for the bilateral Achilles tendon and a +/5 patellar reflex on the right. The reviewer was confused by the + designation on the reflex without a number. His pain scale is a 7/10 on this date. The patient had an ESI on 4/29/08. Pain relief was minimal as per Dr. notes (from an 8/10 to a 7/10).

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

The following two paragraphs are quotes from the ODG regarding ESI and post injection rehabilitation:

“If post-injection physical therapy visits are required for instruction in these active self-performed exercise programs, these visits should be included within the overall recommendations under physical therapy, or at least not require more than 2 additional visits to reinforce the home exercise program.”

“Post Epidural Steroid Injections: ESIs are currently recommended as a possible option for short-term treatment of radicular pain (sciatica), defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The general goal of physical therapy during the acute/subacute phase of injury is to decrease guarding, maintain motion, and decrease pain and inflammation. Progression of rehabilitation to a more advanced program of stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based research that addresses the use of physical therapy post ESIs, but it appears that most randomized controlled trials have utilized an ongoing, home directed program post injection. Based on current literature, the only need for further physical therapy treatment post ESI would be to emphasize the home exercise program, and this requirement would generally be included in the currently suggested maximum visits for the underlying condition, or at least not require more than 2 additional visits to reinforce the home exercise program. ESIs have been found to have limited effectiveness for treatment of chronic pain. The claimant should continue to follow a home exercise program post injection.”

The above information indicates that up to two physical therapeutics sessions could be approved based upon the ODG. However, it is DWC policy to not have

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)