



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 3/3/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include therapeutic rehabilitation (code 97110) times 12 units.

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 has been practicing in Texas for greater than 10 years.

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:
Utilization Review.

These records consist of the following (duplicate records are only listed from one source): records from: an impression page from a lumbar MRI (undated), 1/16/08 evaluation by PT, 1/11/08 exam by DC, 12/24/07 script by, MD and 1/10/08 to 2/21/08 exams by, MD.

Records from the URA include: 2/18/08 letter by, IRO intake paperwork, 1/18/08 denial letter, 1/24/08 denial letter, 1/18/08 and 1/24/08 reports,

1/16/08 and 1/22/08 preauth requests, 1/16/08 PT recommendation letter and 1/17/08 lumbar MRI (not the same second page as that previously listed).

The URA/Carrier did not send a copy of the ODG.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured on or about xx/xx/xx while working on the job. He apparently presented to the company doctor, Dr.. The received records indicate that he has injured his lumbar spine and complains of pain to the right leg. The mid January 2008 records indicate that he has a pain scale of 8/10 and decreased functional abilities. ROM was reduced in all planes. Muscle strength and DTR's were within normal limits. Sensation was reportedly reduced; however, the type of examination performed was not indicated. (2 pt or pinwheel)

He was provided with medications by Dr.. The diagnosis is lumbar disc syndrome with concomitant sprain and radicular syndrome. Lumbar imaging reveals L3/4 disc protrusion with mild encroachment of the L3 nerve on the right, disc herniation annular fissure at L5/S1, disc bulge with facet hypertrophy at L5 and mild L4 foraminal narrowing secondary to bulging and spurring at this level.

The carrier notes that 9 sessions of physical therapy have been provided to this patient. It is not clear from the provider's or the carriers' notes with which provider these sessions have been performed. The evaluation by Mr. indicates that the patient does not meet lifting, walking, carrying, stooping, kneeling, crouching, reaching and handling requirements of his job. He scored a crippled rating on the Oswestry. No postural deviations were observed.

The noted limitations in the patient's walking restriction are not based upon anything in the exam except under gross mobility where it was rated as restricted; however, no reason for the restricted rating was given.

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

The patient's PDL is noted to be heavy when he is at full duty. The 1/16/08 examination finds him at a sedentary level at this point. This is not an acceptable level after 2 ½ to 3 months of care. The reviewer realizes that all care has not been provided by the current provider, regardless, the patient is not where he needs to be at this stage.

However, it is not clear to the reviewer that the requested physical therapy is what is indicated at this point. His previous reaction to PT was not documented in the notes provided and he has apparently not had any form of a pain management consultation to determine the medical necessity of any form of therapeutic injections.

Therefore, based upon the lack of medical information provided by the parties, the proposed care of physical therapy times 12 sessions is found to not be medically reasonable or necessary at this point in time as per the ODG and the reviewer's professional experience.

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)