I-Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 21, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of additional physical therapy, twelve visits over four weeks for the lumbar spine, to include 97110 therapeutic exercises and 97014 electrical stimulation.

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

Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back
Office notes, Dr. 05/14/07
MRI lumbar spine, 05/23/07
Office notes, Dr. 05/24/07, 06/13/07, 06/18/07, 07/09/07, 08/09/07, 09/06/07, 09/26/07
06/13/07
Chiro, 05/15/07-07/06/07
Physical therapy, 01/02/08 – 01/31/08
Prescription, 02/05/08
Peer Review, Dr. 02/06/08
Peer review, Dr. 02/19/08
Therapy, 05/11/07

Pain questionnaire, 05/14/07
Dr. 02/22/07
Imaging, 05/24/07
Dr. 06/14/07, 07/16/07
02/07/08, 02/20/08
Utilization, 03/04/08
Release of Information, 03/11/08
Patient Chart

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female injured when she leaned over in a chair and developed low back and left hip pain. She had an MRI that showed a disc extrusion at L5-S1 with displacement of the left S1 nerve root. She was initially treated with chiropractic without benefit and ultimately underwent L5-S1 decompression and fusion on 07/09/07 with at least initial improvement in the leg pain. The most recent note from the treating physician was dated 09/26/07. The claimant was reported as having no problems and therapy was initiated.

Records indicated that the claimant attended therapy in January of 2008 for stiffness of the low back and legs. Additional therapy for twelve sessions was requested on 02/05/08 but has been denied on two peer reviews.

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

Additional physical therapy does not appear to be necessary or medically indicated for this claimant. Records would support that she has had extensive therapy since her surgery in July of 34-36 visits. This clearly would allow for any gains to have taken place at this point and would also have allowed for proper instruction in a home program. It is unlikely that additional therapy will lead to significant functional improvement. In addition, the amount of treatment to date meets or exceeds that which is recommended in evidence based guidelines. In the absence of information from the physician, the records fail to provide documentation that the claimant would be an exception to those guidelines. Electrical stimulation in this setting cannot be recommended as it has not been found to be efficacious and is not supported by ODG as a useful adjunct to therapy.

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back
Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.
Lumbar sprains and strains (ICD9 847.2):
10 visits over 8 weeks
Sprains and strains of unspecified parts of back (ICD9 847):
10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846):
Medical treatment: 10 visits over 8 weeks
Lumbago; Backache, unspecified (ICD9 724.2; 724.5):
9 visits over 8 weeks
Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):
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 (fusion): 34 visits over 16 weeks

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)**