C-IRO, Inc.

An Independent Review Organization

7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

DATE OF REVIEW: **NOVEMBER 17, 2008**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of physical therapy two three times a week for four weeks; 97110, 97140? (97110 is therapeutic exercises and 97140 is manual therapy)

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

MD, 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)

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.

The reviewer finds that medical necessity does not exist for physical therapy two three times a week for four weeks; 97110, 97140 (97110 is therapeutic exercises and 97140 is manual therapy)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

EMG, 08/24/05
Operative report, 04/04/08
Office notes, Dr., 04/15/08, 06/10/08, 09/24/08
Physical therapy evaluation, 10/02/08
Peer review denial, 10/06/08, 10/23/08

Physical therapy letter, 10/10/08
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male who was status post laminectomy L4-5 in December 2006. Dr. saw the claimant on 04/15/08. The claimant noted good relief from the epidural steroid injection. Spasm and positive straight leg raise on the left was noted.
Motor strength testing was equivocal. Diagnosis was post laminectomy syndrome, improved. Dr. evaluated the claimant on 09/24/08 for exacerbation of pain complaints since last seen. The claimant noted increasing pain down the back of his right leg into the right foot. Range of motion of the lumbar spine was guarded. There was moderate to severe muscle spasm. Straight leg raise on the right was positive at about 35 degrees. Crossed straight leg raise was positive. Motor was 5/5 to the lower extremities. The records reviewed indicated that the claimant has had extensive physical therapy postoperatively. On 10/23/08, Dr. was contacted regarding physical therapy and it was stated that Dr. stated to disregard the request.

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

There is no medical necessity for the requested physical therapy. This claimant is almost 2 years postoperative with residual complaints of low back and right leg pain and more recently an exacerbation of pain complaints. Conservative management and postop recovery was not well documented; however, records reflect that the claimant has had extensive physical therapy to date. That being said and with review of the Official Disability Guidelines Treatment in Workers' Comp 2008 Updates which indicate 16 physical therapy visits following surgery, there is no medical necessity for additional physical therapy. The reviewer finds that medical necessity does not exist for physical therapy two three times a week for four weeks; 97110, 97140 (97110 is therapeutic exercises and 97140 is manual therapy).

Official Disability Guidelines Treatment in Workers' Comp 2008 Updates, low back- physical therapy

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 week

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)**