



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 09/10/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy

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

Board Certified in Preventive & Occupational Medicine
Board Certified in Family Practice

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.

Physical therapy – Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbar spine interpreted by , M.D. dated 01/17/08
Evaluations with , M.D. dated 01/30/08, 02/09/08, 02/15/08, 02/18/08, 03/10/08, 03/13/08, 03/17/08, 04/01/08, 04/21/08, 05/01/08, 05/15/08, 06/04/08, 06/20/08, 07/07/08, 07/22/08, 07/25/08, 08/01/08, 08/18/08, and 08/20/08

A lumbar myelogram CT scan interpreted by , M.D. dated 02/27/08
Prescriptions from , M.D. dated 05/15/08 and 07/24/08
Computerized Muscle Testing (CMT) and Range of motion testing dated
05/15/08 and 07/24/08
DWC-73 forms from Dr. dated 06/04/08, 07/17/08, 07/25/08, and 08/01/08
A physical therapy progress report from , P.T. dated 06/19/08
A preauthorization request letter from an unknown provider (no name or
signature was available) dated 07/07/08
A letter of non-authorization, according to the ODG, from , D.O. dated 07/08/08
Letters of non-authorization, according to the ODG, from , Utilization Review
Nurse at dated 07/08/08 and 07/28/08
A letter from Dr. r dated 07/23/08
A note from , M.D. dated 07/24/08
A letter of non-authorization, according to the ODG, from , M.D. dated 07/28/08
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the lumbar spine interpreted by Dr. on 01/17/08 revealed disc bulging at L3-L4 and L5-S1 and a large disc protrusion at L4-L5. On 01/30/08, Dr. requested physical therapy and a Medrol Dosepak. On 02/15/08, Dr. recommended an EMG/NCV study. A lumbar myelogram CT scan interpreted by Dr. on 02/27/08 revealed disc bulging at L3-L4 and L4-L5 and a disc protrusion at L5-S1. On 04/21/08, Dr. noted the patient was two weeks postoperative. On 05/15/08, Dr. recommended further physical therapy. On 06/19/08, Ms. also requested further physical therapy. On 07/08/08 and 07/28/08, Ms. wrote letters of non-authorization for physical therapy. Dr. wrote a letter of non-authorization for physical therapy on 07/08/08. On 07/22/08, Dr. increased Neurontin and prescribed Ultram and Flexeril. On 07/24/08, Dr. recommended further physical therapy. On 07/28/08, Dr. also wrote a letter of non-authorization for physical therapy. On 08/18/08, Dr. recommended a possible work conditioning program.

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

Per the ODG, up to 16 post surgical physical therapy visits over an eight week period could be considered reasonable and necessary. This patient has participated in a postoperative physical therapy program that appears to have exceeded the recommended levels. Currently, additional therapy is being requested. However, further formal therapy would not provide any benefit over a home exercise program. At this point, therapist administered passive modalities would be no more beneficial than those that could be self applied in a home based setting. Additionally, I am not aware of any specific exercises that could not be adequately performed in a home exercise program. Certainly, I agree that the patient does need ongoing therapy type exercises, but all necessary interventions can be done in a home exercise program, which he should be well-

versed in a home exercise program. Therefore, I agree with the previous adverse determinations and the denial for additional formal physical therapy is upheld.

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)