



Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 8/24/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for 12 sessions of multi modality Physical Therapy, including 97110, 97140, 97112, 97530, 97035, G0283 and 97018.

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

Texas licensed 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 previously denied request for 12 sessions of multi modality Physical Therapy, including 97110, 97140, 97112, 97530, 97035, G0283 and 97018.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Email Message dated 8/17/09, 8/7/09.
- Letter dated 8/7/09.
- Notice to. of Case Assignment dated 8/5/09.
- Cover Letter dated 8/4/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 8/3/09.
- Evaluation Report dated 7/17/09, 6/25/09, 5/22/09, 5/11/09.
- Patient Demographic Sheet dated 7/11/09, 5/11/09.
- Adverse Determination After Reconsideration Notice dated 7/7/09.
- Re-Evaluation/Progress Report dated 6/30/09, 6/4/09.
- Treatment Log dated 6/30/09, 6/8/09, 6/4/09, 6/3/09, 6/2/09.
- Therapy Referral/Hand Therapy Center Form dated 6/25/09, 5/5/09.
- Chart Note dated 6/22/09.
- Adverse Determination Notice Letter dated 6/15/09.
- Progress Report dated 6/3/09.
- Lumbar Spine MRI Results dated 5/15/09.
- Initial Evaluation Report dated 5/6/09.
- Codes for Automated Approval/Guidelines (unspecified date).
- Guidelines Sheet (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years
Gender: Female
Date of Injury: xx/xx/xx
Mechanism of Injury: Unloading cases of soda
Diagnosis: Lumbar strain

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

The claimant is a xx-year-old female with the date of injury of xx/xx/xx. The mechanism of injury was unloading cases of soda. The diagnosis was lumbar strain. The claimant had received 10 sessions of physical therapy as of the July 7, 2009 where 12 additional physical therapy sessions were requested on June 12, 2009. The August 7, 2009, a letter of response to the requested trial indicated the claimant's diagnosis was lumbar strain/sprain. It noted the claimant had 12 sessions of physical therapy and the request was not supported by the relevant ODG Guidelines. The MRI performed on May 15, 2009 noted mild old compression superior S1 with multiple level lower lumbar spondylosis, mild to

moderate canal stenosis at L5-S1 and mild at L4-L5 with a small protrusion at L4-L5. Dr. Boone was seeing the patient for the back complaints and had recommended the physical therapy. On June 22, 2009, he noted the denial for physical therapy. He indicated that the claimant had back pain and felt therapy with specified modalities would help decrease inflammation, increase function. He noted on June 25, 2009, the claimant was not doing well and epidural steroid injection (ESI) had been discussed. The physical examination revealed mild spasm, decreased motion in the extremes with no focal neurological deficits noted. The June 30, 2009 re-evaluation of physical therapy noted normal lumbar range of motion (ROM) with 4/5 gastrcnemius, hip adductors, quadriceps, and abdominal weakness noted. On August 17, 2009, conservative treatment was again recommended by Dr. after going over the MRI with the patient. The rationale for non-certification of the requested additional physical therapy is that the medical records did not contain the information that would support the need to deviate from ODG criteria support that "10 visits over 8 weeks" with active modalities for this condition. This claimant has completed at least 10 sessions to date.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 7th Edition (web), 2009, Low back-Physical therapy.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).