



Notice of Independent Review Decision

DATE OF REVIEW: 12/07/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy, lumbar, twelve visits, three times a week times four weeks

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified by the American Board of Physical Medicine and Rehabilitation and member of North American Spine Society

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
	97010		Prosp	12					Upheld
	97014		Prosp	12					Upheld
	97035		Prosp	12					Upheld
	97110		Prosp	12					Upheld
	97113		Prosp	12					Upheld
	97116		Prosp	12					Upheld
	97124		Prosp	12					Upheld
	97140		Prosp	12					Upheld
	97530		Prosp	12					Upheld

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letter of denial and physician reviewer, final report, 11/17/09
3. Letter of denial and physician reviewer, final report, 11/06/09, including criteria used in the denial
4. Evaluations 10/26/09 and 11/02/09

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This is a male injured employee. This occurred on xx/xx/xx. According to the records, he was evaluated and he went on to have an MRI scan of the lumbar spine on 03/18/09. By report this showed multilevel lumbar spondylitic changes as well as severe right foraminal narrowing at the L5/S1 level and moderate left subarticular foraminal protrusion at the L4/L5 level with moderate left foraminal narrowing. He went on to see multiple physicians including an orthopedic surgeon, and an L5 level artificial disc replacement

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was ordered but denied by P.A. The patient also had had limited relief with conservative treatment including physical therapy and oral medications including steroids. He also had an epidural steroid injection with no long term benefit. In November 2009 the patient was evaluated, and twelve visits for physical therapy were ordered and subsequently denied.

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

Considering the afore-noted information and the length of time from the patient’s initial injury, twelve more physical therapy visits are not currently medically warranted. The rationale for this decision is based primarily on the ODG Guidelines, as well as the North American Spine Society clinical algorithms for multilevel lumbar degenerative changes.

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

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature.
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)