



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 07/31/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

16 Sessions of Physical Therapy for the Lumbar Spine

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

Board Certified in Physical Medicine & Rehabilitation

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.

16 Sessions of Physical Therapy for the Lumbar Spine - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- RI of the Lumbar Spine, , M.D., 09/02/05
- Post-Discogram CT of the Lumbar Spine, M.D., 07/09/07
- Three Level Lumbar Spine Discogram, Dr. , 07/09/07
- Peer Review, , D.O., 01/15/09

- Range of Motion Examination, , M.D., 02/16/09, 05/28/09
- Follow up Visit, Dr. 04/29/09
- Physical Assessment Evaluation and Treatment Plan, 05/13/09
- Pre-Authorization, 05/14/09, 06/29/09
- Denial Letter, 1, 05/18/09, 06/08/09, 07/08/09
- Request for Reconsideration, , 06/26/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained an injury to his lower back on xx/xx/xx. He had been treated conservatively, undergone an MRI of the lumbar spine, as well as a discogram of the lumbar spine. He also underwent an anterior/posterior decompression and fusion from L4-S1. He had most recently been prescribed Norco, Trazodone, Mobic and Ultram.

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

The sixteen additional sessions of physical therapy for the lumbar spine are neither medically reasonable or necessary.

I had the opportunity to review the provided documentation for this case at length. Dr. has requested sixteen visits of physical therapy to follow eighteen visits already completed. The patient has had two previous courses of physical therapy, one prior to the 10/29/07 fusion and one session after the 10/29/07 fusion. This request has been denied two previous times as the patient did not demonstrate any significant evidence of functional improvement. In the rebuttal letter, Dr. indicated that the patient had increased his lumbar range of motion significantly but had significant strength loss due to atrophy of the right thigh and calf. He uses the basis of decision for physical therapy as “post surgical treatment, fusion, after graft maturity” for intervertebral disc disorder. The ODG Guidelines indicate that 34 visits are authorized over sixteen weeks. While I generally concur that this is the ODG criteria, this patient is not truly undergoing “post surgical physical therapy.” These therapy visits did not begin until eighteen months post fusion, and the patient did receive six visits of postoperative physical therapy. This current course of treatment is more in the order of pain management and not a true postoperative physical therapy program. As such the ODG criteria for postoperative rehabilitation does not apply in this case. Furthermore, while Dr. has provided evidence of objective improvement in range of motion and strength, there is no provided objective or subjective improvement in function. Therefore, by the ODG criteria for physical therapy, the patient does not meet the criteria for further provision of physical therapy.

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)**