

C-IRO Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199B
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/12/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Post injection physical therapy visits over 3 weeks (77035, 97032, 97110, 97140)

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

MD, Board Certified in Physical Medicine and 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

This is a woman with neck and upper back pain and upper extremity pain since a xx/xx/xx injury. She had a pre-existing nerve decompression in 1987. She had 3 cervical operations with fusion in 1995 and in 1997, the latter being an anterior fusion from C3 to C7. She had progressive increase in her pain in the past year. Dr. arranged for an EMG/NCV in July 2009 that showed a bilateral C4 and a left C5/6 radiculopathy. Dr. requested preauthorization for a C7/T1 interlaminar ESI followed by 3 sessions of physical therapy. This was discussed in the provider's 8/3/09 and 8/17/09 notes.

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

The subject of this review is not the medical necessity for the C7/T1 interlaminar ESI, but the medical necessity for post injection physical therapy. The ODG recommends 1-2 therapy sessions over 1 week, post injection. It emphasizes active therapy with mobilization limited to acute problems with a self-directed active program. The provider in the case (Letter Dated 9/2/09) has requested "3 days post injection PT." When one considers the chronicity of this patient's case and the three cervical surgeries in the past, as well as the provider's recommendation and the recommendations in the guidelines, the reviewer finds that medical necessity exists for post-injection physical therapy visits over 3 weeks (77035, 97032, 97110, 97140).

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)