

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 03/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3 times a week for 4 weeks

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

The TMF physician reviewer is board certified in internal medicine with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the physical therapy 3 times a week for 4 weeks is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 03/15/10

- Notice of Utilization Review Findings – 01/26/10, 02/16/10
- Plan of Care from Physical Therapy Today – 01/06/10
- Request for Physical Therapy from Dr. – No date
- Prescription for Physical Therapy from Dr. – 12/28/09
- Encounter by Dr– 12/29/08 to 02/02/10
- Appeal Letter from Dr. – 10/09/08
- Office visit notes from Dr. – 09/23/08 to 10/06/08
- Letter from Dr. – 09/23/08, 10/27/08,11/05/08
- Operative report by Dr. – 07/16/08
- Report of x-ray of the lumbar spine – 09/23/08
- Notice of Disputed Issue(s) and Refusal to Pay Benefits – 04/02/08, 04/03/08
- Physical Therapy Functional Capacity Evaluation – 05/20/08
- Report of CT scan of the lumbar spine – 06/05/08
- Report of radiological examination of the thoracic/lumbar spine – 12/03/09
- Emergency department record– 02/05/08, 06/05/08
- Worker's Compensation Initial Evaluation Report by Dr. – 02/12/08
- Progress reports by Dr. – 02/16/08 to 07/08/08
- Office visit notes by Dr. – 02/21/08 to 05/15/08
- Psychological Assessment by Dr.– 03/07/08
- History and Physical by Dr. – 03/27/08
- Psychotherapy Progress notes by Dr. – 04/09/08 to 06/10/08
- History and Physical by Dr.– 04/12/08
- Emergency department record– 04/12/08
- WC Program daily progress notes – 04/21/08 to 06/05/08
- Re-examination for Work Hardening by Dr. - 05/08/08
- Report by Dr– 06/29/08
- Follow up Report by Dr. – 07/02/08 to 07/09/08
- Follow up Report by Dr. – 04/21/08 to 10/28/08
- Office visit notes by Dr. – 10/27/08 01/23/09
- Operative note by Dr – 02/01/09 to 02/24/09
- Clinic Notes by Dr. – 05/18/09 to 12/02/09
- Initial Physical Therapy Evaluation – 05/20/09
- Physical Therapy Progress/Treatment Notes – 05/20/09 to 01/22/10
- Designated Doctor Evaluation by Dr. – 05/06/08 to 10/24/08
- Required Medical Examination by Dr. – 10/01/08
- Medical Record Review by Dr. – 11/24/08
- History and Physical by Dr.– 08/05/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when she fell down stairs resulting in low back pain as well as bilateral leg pain. She has been diagnosed with a protrusion at L5-S1. She has been treated with physical therapy, Work Hardening, epidural steroid injections and medications. The treating physician is recommending additional physical therapy 3 times a week for 4 weeks.

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

This patient sustained a back injury on xx/xx/xx. Based on the medical record documentation, the patient had minimal response even acutely to therapy. In addition, there are multiple examinations after this by physicians who mention a lack of anatomic reasons for the patient's complaints, inconsistent examinations and questions raised of somatization. Guidelines do not support the need for physical therapy at this point for an injury that occurred over two years ago with the information that the patient apparently had poor response to physical therapy even initially. Therefore, it is determined that physical therapy at this point is not medically indicated.

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)