



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 04/19/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 Sessions of Physical Therapy of 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 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)

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.

12 Sessions of Physical Therapy of the Lumbar Spine - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Employer's First Report of Injury or Illness, Associates, xx/xx/xx
- Initial Consultation, M.D., 12/21/09
- DWC Form 73, Dr. 12/21/10, 01/04/10, 02/03/10, 03/03/10
- Chiropractic Therapy, Clinic, 12/22/09, 12/23/09, 12/24/09, 12/28/09, 12/30/09, 01/04/10, 01/06/10, 01/08/10, 01/11/10, 01/12/10, 01/15/10, 01/15/10, 01/19/10, 01/21/10, 01/25/10, 01/27/10, 01/28/10, 02/01/10, 02/02/10, 02/03/10, 02/17/10, 02/18/10, 02/23/10
- Consultation, Dr. 01/04/10, 02/03/10, 03/03/10
- MRI of the Abdomen, M.D., 01/13/10
- MRI of the Lumbar Spine, Dr. 01/13/10
- MRI of the Cervical Spine, Dr. 01/13/10
- Prescription of Medical Necessity, Dr. 01/27/10
- Peer Review, 02/15/10
- Notice of Denial of Compensability/Liability and Refusal to Pay Benefits, AR Claims Management, 02/19/10
- Physical Therapy Progress Note, Dr. 02/25/10
- Request for Pre-Authorization, Dr. 03/01/10, 03/11/10
- Denial Letter, 03/01/10, 03/05/10, 03/11/10, 03/18/10
- Request for Reconsideration, Dr. 03/10/10
- Correspondence, Dr. 04/05/10
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained a slip and fall injury to her cervical, thoracic and lumbosacral spine regions. She was initially treated with Darvocet, Ultram ER, Mobic and Zanaflex. She attended physical therapy three times per week for four weeks. An MRI was obtained of her abdomen, which was normal. An MRI of the cervical spine indicated a 2 mm focal disc protrusion at C6-C7, as well as what appeared to be a bony protrusion at C5-C6. An MRI of the lumbar spine showed dehydration and desiccation of the L1-L2, L4-L5 and L5-S1 discs, as well as a 2-3 mm broad based extradural defect with moderate neural foraminal narrowing at L4-L5. She was continued on her medications and more therapy had been requested.

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

The date of injury is approximately four-and-a-half months in age. The primary medical condition referable to any affected region of the body would appear to be that of a muscular strain. Such a condition is a medical condition, which is typically considered to be self-limiting in nature. The claimant has received access to at least 23 sessions of

supervised rehabilitation services. For the described medical situation, Official Disability Guidelines would support an expectation that an individual should be capable of a proper, nonsupervised rehabilitation regimen when individuals receive the amount of supervised rehabilitation services previously provided.

Consequently, per criteria set forth by the Official Disability Guidelines, treatment in the form of supervised rehabilitation services would not be considered to be of medical necessity. The above-noted reference would support an expectation that an individual should be capable of a proper nonsupervised rehabilitation regimen when one has received the amount of supervised rehabilitation services previously provided. The described mechanism of injury would be expected to result in a medical condition of a muscular strain. Additionally, radiographic studies accomplished after the date of injury did not reveal any findings worrisome for an acute pathological process. Thus, based on the records available for review, there is not a medical necessity established for treatment in the form of supervised therapy services at the current time.

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)**