

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 4/13/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient physical therapy (PT) to the lumbar spine three (3) times a week for four (4) weeks for twelve (12) sessions

QUALIFICATIONS OF THE REVIEWER:

Physical Med & Rehab, Pain Management

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)

Outpatient physical therapy (PT) to the lumbar spine three (3) times a week for four (4) weeks for twelve (12) sessions Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice to by author unknown, dated 3/24/2010
2. Notice to utilization review by dated 3/24/2010
3. Fax page dated 3/22/2010
4. Letter by, dated 3/22/2010
5. Request form by author unknown, dated 3/16/2010
6. Letter by author unknown, dated 2/23/2010
7. Fax page dated 2/23/2010
8. Letter by, dated 2/23/2010
9. Notice of utilization review by author unknown, dated 2/23/2010
10. Letter by, dated 2/23/2010
11. Fax page dated 2/16/2010
12. Medical history by DC, dated 2/11/2010
13. Functional capacity evaluation by author unknown, dated 2/11/2010
14. Physical performance evaluation by author unknown, dated 2/11/2010
15. Notice of utilization review by author unknown, dated 2/10/2010
16. Notice to utilization review by author unknown, dated 2/10/2010 & 2/23/2010
17. Fax page dated 2/4/2010
18. History note by MD, dated 1/29/2010
19. Prescription note by MD, dated 1/29/2010
20. MRI lumbar spine by MD, dated 1/28/2010
21. Denial information by author unknown, dated 12/17/2009
22. Injury information by author unknown, dated 12/17/2009
23. Form for requesting a review by author unknown, dated unknown
24. Workman's comp dated unknown
25. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male who injured low back while lifting and dragging pallets on xx/xx/xx. He presented with diagnoses of lumbago, lumbar radiculitis and lumbar disc displacement. Lumbar MRI revealed disc bulges at L4-5, L5-S1 without neural compression or stenosis. Plan is lumbar support, physical therapy (PT), local heat and lifting restrictions. On 2/11/10 an FCE (functional capacity exam) was performed which noted the injured employee was at a Medium physical duty capacity but his usual work required medium to heavy capacity. Psychological intervention was recommended due to poor psychodynamics and inappropriate pain behaviors. Further physical therapy was recommended.

IRO submitted request regarding PT 3 times per week for 4 weeks. Request was denied by peer review on 2/10/10 and 2/23/10.

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

The injured employee suffered a lumbar injury on xx/xx/xx and no previous conservative treatment is documented other than oral medication. It is unclear what treatment the injured employee has had to date with the 1/29/10 note offering little detail. A 2/26/10 note states the injured employee is stable, perhaps slightly improved. Diagnosis is lumbar sprain and bulging disks. The physician at that time recommended physical therapy (PT), elastic lumbar support, work restrictions and local heat. It is noted on the 2/26/10 note the injured employee has not had any PT treatments. The request ordered is for 12 visits. For initial therapy due to a lumbar injury, ODG recommends a 6 visit trial of therapy to assess patient response and compliance with the treatment program with 10 visits recommended overall with graduation to home exercises thereafter. Given that the number of sessions exceeds ODG recommendations for standard treatment protocol of lumbar sprain, the requested treatment is not considered medically necessary. Recommendation is that prior denials of physical therapy be upheld.

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)