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Notice of Independent Review Decision

DATE OF REVIEW: 03/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97110 Therapeutic exercises

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

This case was reviewed by a Texas licensed MD, specializing in Pain Management, Anesthesiology. The physician advisor has the following additional qualifications, if applicable:

ABMS Anesthesiology: Pain Medicine, Anesthesiology

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Partially Overturned

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Therapeutic exercises	97110, 97113, 97112, 97035, 97140, 97010, G0283	-	Partially Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request	TDI	15	03/10/2010	03/10/2010
2	First Report of Injury		4	04/07/2009	04/09/2009
3	IRO Carrier/URA Records		2	03/12/2010	03/12/2010
4	IRO Request		7	03/08/2010	03/10/2010
5	PT Notes		12	04/15/2009	05/20/2009
6	Diagnostic Test		2	07/03/2009	07/03/2009
7	Claim Dispute Notice		2	07/22/2009	07/22/2009
8	Office Visit Report		4	08/20/2009	08/20/2009
9	PT Notes		5	08/20/2009	09/01/2009
10	Op Report		3	01/14/2010	01/14/2010
11	Office Visit Report		10	12/16/2009	02/10/2010
12	PT Notes		5	02/10/2010	02/12/2010
13	Office Visit Report		52	04/09/2009	02/17/2010

14	IRO Record Receipt	TDI-DWC	4	03/09/2010	03/09/2010
15	Initial Denial Letter		5	02/18/2010	03/12/2010

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a male with date of injury of xx/xx/xx. The mechanism of injury occurred while lifting copy paper. There was an injury to the lower back. The patient was seen and received 10 sessions of physical therapy; in April and May of 2009. No improvement was noted and an MRI was performed on 07-03-09. It was notable for a mild subarticular disc protrusion at L5-S1. The patient was seen by Dr. xxxxxx on 08-20-09 and aquatic therapy and an epidural steroid injection was recommended. The patient was evaluated for aquatic therapy on 08-20-09 at xxxxxx Hospital. The patient was seen by Dr. and an ESI was performed on 01-14-10. There was a subsequent request for further post-injection PT by Dr. for 12 sessions and was denied.

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

In this patient there was no benefit from the initial 10 sessions of physical therapy. There was a recommendation for further PT post ESI. The ODG will support only 1-2 sessions of PT for post injection purposes. Therefore only 2 sessions of PT is supported by the ODG and is considered medically necessary.

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

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#), including assessment after a "six-visit clinical trial".

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

- 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)