

# Wren Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/26/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Outpatient physical therapy to the lumbar spine, 3 x 4 weeks, for post laminectomy syndrome.

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified in Physical Medicine & 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

ODG Guidelines and Treatment Guidelines  
Adverse Determination Letters, 11/16/09, 12/1/09  
Pain and Wellness, 12/7/09, 11/5/09, 10/1/09, 9/3/09, 5/7/09,  
3/9/09, 4/9/09, 2/23/09, 2/4/09, 11/10/09, 12/8/09  
Services 11/13/09, 12/1/09

### PATIENT CLINICAL HISTORY SUMMARY

This is a man with a date of injury of x/xx/xx. The MRI done in 2008 showed disc protrusion at L1/2, bulges at L2/3, L3/4 and a disc replacement at L4/5. He has ongoing back and lower extremity pain. Psoas block did not help. Prior reviewer report notes the patient is status post low back surgery xxxx years ago. The patient reportedly had PT in the past and there is at this time a request for outpatient physical therapy to the lumbar spine, 3 x 4 weeks, for post laminectomy syndrome.

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

The ODG recognizes the role of physical therapy as an alternative to surgery and for treatment after surgery. The maximum amount of therapy advised is for 48 visits over a period of 18 weeks. The ODG recommends that these therapies are to be followed by a home exercise program after a period of fading. There is no description in the records provided of what the anticipated goals of formal therapy are in this case that could not be obtained from a home program. It appears from the records that the request for the additional therapies is because the physician states there is no other treatment to offer. Based upon the evidence based criteria used in the ODG, this would not be justification for additional

therapies this long after the surgery. The request does not conform to the ODG guidelines. The reviewer finds that medical necessity does not exist for Outpatient physical therapy to the lumbar spine, 3 x 4 weeks, for post laminectomy syndrome.

**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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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