

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 04/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy lumbar x6 visits 2xwk x3wks

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

The TMF physician reviewer is a licensed chiropractor 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 proposed physical therapy lumbar x6 visits 2xwk x3wks is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Preauthorization determination letter from– 03/05/10, 04/06/10
- Preauthorization request from post injury rehabilitation from Specialty Group – 02/17/10, 03/09/10, 04/12/10
- Office visit notes to Specialty Group – 01/11/10 to 03/05/10
- Computerized Spinal Range of Motion report – 01/18/10
- Report of Isometric Muscle Testing Exam – 01/15/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when she was lifting a large bag of blankets and felt a pop in her lower back followed by immediate pain. She was treated with physical therapy then surgery followed by participation in a pain management program. She has had a flare up of her condition and the treating chiropractor is recommending that she had additional physical therapy visits.

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

The medical record documentation indicates that this patient has received an intense treatment program since her original date of injury. Diagnostic testing in the form of

lumbar spine MRI, lumbar myelogram/CT, lumbar discogram/CT, functional capacity evaluations and electrodiagnostic testing were performed. Treatment has included chiropractic care, physical therapy, medication, epidural steroid injections, chronic pain management program and lumbar laminectomy with fusion in September 2006. After surgery the patient received postsurgical rehabilitation, individual psychotherapy and a work hardening program that had to be stopped due to pain complaints. Over the next few years the patient received a caudal epidural steroid injection and lysis of adhesions which was performed on 09/10/08. These were repeated on 11/19/08. A follow-up note on January of 2009 indicates that the patient was near resolution of her leg pain with two epidural steroid injections. Over the years her treatments have far exceeded the acceptable physical therapy ODG guidelines (ODG online PT-physical therapy and ODG online pain-physical medicine treatment). There is no clinical documentation that would indicate that an additional 6 physical therapy units as requested would improve her current clinical presentation. The requested physical therapy does not meet the criteria of the ODG guidelines.

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)