

C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3xWk x 4 Wks lumbar 97110 97112 97140

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

MD, 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Physical Therapy Guidelines
ADVERSE DETERMINATION LETTERS, 3/8/10, 3/25/10
Clinic, Dr. MD, 2/24/10, 3/10/10, 4/19/10

PATIENT CLINICAL HISTORY SUMMARY

This is a man with a prior laminectomy injured on xx/xx/xx. He developed back pain. The MRI showed a 3mm disc herniation at L3/4, 6mm at L4/5 and 6mm at L5/S1. He had at least 21 sessions of PT and remains with local tenderness and limited motion. An additional 12 sessions of PT are requested.

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

Dr. reports this man made gains with therapy, but needs to make more. He has marked limitation in lumbar motion in all planes, and weakness after 21 sessions of therapy. The records do not contain evidence that the patient is demonstrating objective gains. The ODG requires reducing the number of formal treatment sessions and increasing the self directed ones at home. There were no records regarding this patient's participation at home. For nonoperated back pain programs, the ODG recommends up to 10 sessions over 8-10 weeks. This patient has had twice that allotted amount, presumably to compensate for the prior back operations. There was no objective information provided why and how the additional treatments would accomplish what has not been accomplished to date. The reviewer finds

that medical necessity does not exist for Physical Therapy 3xWk x 4 Wks lumbar 97110
97112 97140.

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)