Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 10/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of PT 3x a week for four weeks (97110, 97140 and G0283)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a licensed Doctor of Chiropractic. This reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of 12 sessions of PT.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties: DC and.

These records consist of the following (duplicate records are only listed from one source): Dr.: preauth requests 8/18/10 and 10/4/10, IRO request for PT letter 10/4/10, 9/22/10 denial letter, 9/15/10 reconsideration for PT letter, 8/24/10 denial letter, 8/5/10 eval by spine and rehab (SASR), SOAP notes from unknown party dated 8/5/10/10 to 10/6/10, 8/3/10 to 9/7/10 subsequent eval notes by MD, 9/15/10 eval report by Dr., 3/1/10 neurodiagnostic report and 1/4/10 CT and MRI reports (thoracic).

: 5/25/10 thoracic CT report and 7/29/10 SOAP notes by MD.

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a male who was injured at work on or about xx/xx/xx. The treating doctors' notes indicate the patient has suffered an exacerbation and requires PT to help reduce pain and increase motion. The peer reviewer notes that 6 visits of PT were performed in November of 2009.

Dr. exam in August of 2010 indicated left sided reflexes reduced to 1+ on the left side in both the upper and lower extremity. SLR was noted positive bilaterally. ROM was reduced in all phases of the cervical and lumbar spine to a severe degree.

Dr. exam on 8/3/10 indicates a normal neurological examination. The neurodiagnostic report in March 2010 indicates the patient is neurologically stable.

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

The ODG indicates that PT is recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. Direction from physical and occupational therapy providers can play a role in this, with the evidence supporting active therapy and not extensive use of passive modalities. The most effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle-strengthening exercises seem to be the most effective types of exercises for treating chronic low back pain. The maximum number of visits has not been exceeded.

The treatment being requested is a little outside the normal purview of the ODG in the reviewer's opinion. The patient was given PT during the first week after injury. Continuation of this program was apparently not requested or documented according to the record. Therefore, the patient is allowed to perform the requested procedures as there is a great chance of improvement in this patient at this time. Due to the chronicity of the patient's condition a slight increase is allowed in the number of visits normally allowed by the ODG

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)