

C-IRO Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199A
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/10/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 2xWk x 4Wks Lumbar spine 97110 97140 97530 G0283

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

M.D., Board Certified Orthopedic Surgeon

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

Official Disability Guidelines, Low Back, Physical Therapy (PT)

Dr. 06/09/10

Prescription 06/09/10

MRI 06/03/10

10/05/10, 10/19/10

Therapy 06/16/10, 09/30/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a, male injured on xx/xx/xx. He had diagnoses that included neck pain, thoracic pain, compression fracture T7, low back pain, sacroiliitis and an annular tear. An MRI was completed on 06/09/06 and showed the old T7 vertebral fracture, L3-4 moderate facet hypertrophy, L4-5 bilateral facet hypertrophy and L5-S1 mild degenerative loss of disc height, annular tear and a minuscule disc protrusion. The claimant was seen on 06/09/10 by Dr. for low back and left buttock pain. The examination documented a normal neurological evaluation. Dr. referred the claimant for physical therapy. A 09/30/10 therapy report indicated the claimant had 20 percent improvement with therapy after 13 sessions but pain in the low back had recently increased.

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

The records do not support that additional Physical Therapy of two times a week for four weeks to lumbar spine is medically necessary. The claimant has had 13 sessions of therapy with minimal improvement as documented by the therapist. In fact, pain had increased as of

the 09/30/10 report. Official Disability Guidelines recommends 8 to 10 visits of therapy for nonsurgical diagnoses. The claimant has exceeded this recommendation without significant improvement. There are no neurological deficits. Nothing would support that this claimant cannot perform an independent program with equal results at this time. While additional therapy can be certified, there must be exceptional factors documented. There is no persuasive documentation of that nature in the file reviewed. Therefore, Physical Therapy 2xWk x 4Wks Lumbar spine 97110 97140 97530 G0283 is not medically necessary.

Official Disability Guidelines 2010. 15th Edition, Low Back

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"

Lumbar sprains and strains (ICD9 847.2)

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847)

10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846)

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5)

9 visits over 8 weeks

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

Intervertebral disc disorder with myelopathy (ICD9 722.7)

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis (ICD9 724.0)

10 visits over 8 weeks

See 722.1 for post-surgical visit

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4)

10-12 visits over 8 weeks

See 722.1 for post-surgical visit

Curvature of spine (ICD9 737)

12 visits over 10 weeks

See 722.1 for post-surgical visit

Fracture of vertebral column without spinal cord injury (ICD9 805)

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury (ICD9 806)

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Work conditioning (See also)

When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.

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)