

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 09/27/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy 2 X Wk X 4 Wks, lumbar the 1 X 4 97032, 97035, 97110, 97112, 97140

DESCRIPTION OF QUALIFICATIONS OF THE REVIEWER:

Doctor of Chiropractic; Diplomate, Congress of Chiropractic Consultants, 25 years of active clinical chiropractic practice, certified through the Texas Department of Insurance/Division of Workers' Compensation in Impairment Rating and Maximum Medical Improvement, Designated Doctor.

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
722.2	97032		Prosp.						Upheld
724.4	97035		Prosp.						Upheld
846.0	97110		Prosp.						Upheld
728.82	97112		Prosp.						Upheld
729.1	97140		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

1. Certificate of Independence of the Reviewer.
2. TDI case assignment.
3. Letters of denial 08/25/10 & 09/07/20, including criteria used in the denial.
4. Diagnostic imaging MRI, lumbar spine 07/09/10
5. Chiropractic evaluation 07/13/10.
6. Treating doctor's correspondence to carrier 07/15, 08/12, 08/19, 08/26 & 09/07/2010.

NOTE: Physical therapy evaluations and treatment for the period of 2005-2008 were available to this reviewer upon request. After reviewing the records provided, there was no need to review records from this period of time.

SUMMARY OF INJURED EMPLOYEE'S CLINICAL HISTORY:

This patient was injured at work on xx/xx/xx, while lifting and trying to turn over a very large and heavy cabinet (approximately 300+ pounds) with a co-worker.

The records indicate the patient has received prescription medication for pain and twelve (12) visits of physical therapy. On 07/09/10 a lumbar spine MRI revealed multiple level and lumbar disc bulges-herniations, along with disc extrusions. He experienced an exacerbation of his condition in early August.

A request for additional therapy was denied. Reconsideration of that request resulted in denial as well. In a letter from the treating doctor regarding expedited reconsideration for imminent or ongoing services dated 08/26/10, the doctor indicated that if after twelve (12) additional therapy visits the patient was not responding, a neuro-surgical consult would be requested.

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

This patient has had more therapy visits than allowed by the ODG guidelines for his diagnosis and condition. Due to the fact that the radicular symptoms have now expanded after the exacerbation, and goes to the right buttocks, it is apparent that the patient has not responded adequately to the physical therapy and chiropractic care he has received to date.

Given the significance of this patient's injuries, the four-month timeframe since his original injury and his minimal results received from his initial twelve (12) therapy visits, it is not reasonable, usual, customary or medically necessary for him to receive an additional twelve (12) physical therapy visits. There is no supportive documentation or clinical justification for this additional physical therapy.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THIS 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)