



5068 West Plano Parkway Suite 122
 Plano, Texas 75093
 Phone: (972) 931-5100

Notice of Independent Review Decision

DATE OF REVIEW: 09/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

IRO- PT Lumbar Spine x 12 visits (97110, 97530, 97140, 97002, 97001)

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
IRO- PT Lumbar Spine x 12 visits (97110, 97530, 97140, 97002, 97001)	97110, 97530, 97140, 97002, 97001	N/A	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request		15		
2	Appeal Denial Letter		4	08/02/2010	08/11/2010
3	IRO Request		4	09/02/2010	09/08/2010
4	Office Visit Report	(MD)	3	06/24/2010	07/22/2010
5	PT Notes		6	07/02/2010	07/02/2010
6	Initial Request		3	07/07/2010	07/07/2010
7	Initial Denial Letter		3	07/13/2010	07/13/2010

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with a DOI xx/xx/xx. The medical records submitted with this request to preauthorize 12 visits of physical therapy do not mention a mechanism of injury. There is mention of a 3 level instrumented lumbar fusion. There are notes from medical care provided on 7/2/10, however, the current medical circumstances are not documented. There are no updated physical findings. The diagnosis is "failed back syndrome". In the 7/10 office note, the patient complains of intermittent pain radiating into the bilateral LEs. The status of the lumbar fusion is not well documented. The implication is that the patient is suffering painful fixation hardware. This request was denied on initial and appeal level review. This is an IRO review for the medical necessity of PT x 12 sessions.

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

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".

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

1. Is the performance of 12 sessions of physical therapy medically necessary and appropriate at this time?

No. There is insufficient current documentation of clinical circumstances to justify the performance of 12 sessions of physical therapy at this time. There is little documentation provided of past treatment other than a 3 level lumbar fusion performed some years ago. The number of sessions of Physical Therapy provided, if any, is unknown. The status of the fusion mass is not documented. The method of the fusion is not documented. In the absence of adequate current medical documentation, this request is not medically necessary.

ODG guidelines potentially support providing some PT in a patient who is post lumbar fusion. However, available information is inadequate to support endorsing PT to the lumbar spine at this time. The prior denials appear to be appropriate and should be upheld

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)