

Notice of Independent Review Decision
IRO REVIEWER REPORT

DATE OF REVIEW: 09/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97110 Cont. Physical Therapy Lumbar Spine x6 Sessions; 4 Units per Session

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

The TMF physician reviewer is a licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the 97110 Cont. Physical Therapy Lumbar Spine x6 Sessions; 4 Units per Session is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 08/26/10
- Decision letter from – 08/18/10, 08/23/10
- Amended Initial Consultation by Dr.– 07/16/10
- Patient Re-Evaluations by Dr.– 05/04/07 to 08/11/10
- Request for Preauthorization from Dr. - 08/13/10
- Request for Reconsideration from Dr.– 08/17/10
- IRO Summary from Claims Management Inc. – 08/26/10
- Notice of Disputed Issue(s) and Refusal to Pay Benefits from – 08/16/10
- Worker's Comp Request for Medical Care – 04/23/10
- Initial Consultation by Dr.– 03/07/10, 06/03/10
- Letter of Causation by Dr.– 06/29/10
- Report of MRI of the lumbar spine – 08/14/10
- Employee's First Report of Injury or Illness – 03/02/07
- History and Physical Examination – 02/26/07
- Texas Worker's Comp Work Status Report – 03/05/07
- Report of MRI of the left shoulder – 04/12/07
- History and Physical Examination by Dr.– 04/12/07
- Letter of Medical Necessity for Neuromuscular Stimulation Unit Monthly Supplies – No Date (illegible signature)

- Prescription for EMS Unit by Dr.– 04/02/07, 05/02/07
- Fitting & Patient Acceptance form - 04/02/07
- Letter of Medical Necessity for Neuromuscular Stimulation Unit by Dr.– no date
- Daily progress notes by Dr.– 04/04/07 to 11/30/09
- Report of functional capacity examination – 09/14/07, 12/05/07
- Office notes by Dr.– 11/30/07 to 11/06/09
- Notice of Independent Review Decision from – 10/12/07
- Impairment and Maximum Medical Improvement Determination by Dr.– 12/10/07
- Report of Muscle Test and ROM – 11/06/09
- Notice of Independent Review Decision by – 04/07/10
- Notes from, Dr. for injury of 06/02/10 – 06/18/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient with a history of a previous back injury sustained a work related injury on xx/xx/xx when he was bending over to pick items from the floor and felt sudden pain in his back radiating down the left leg. The patient has undergone chiropractic care and the treating chiropractor has recommended that the patient undergo physical therapy treatments.

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

Based upon the documentation to include the radicular symptoms and MRI findings, the patient has had only 2 physical therapy visits since his new injury. The requested additional 6 visits of physical therapy are well within the guidelines. The patient is entitled to receive the necessary medical care for his new injury. Therefore, based upon his continued subjective symptoms, his clinical objective findings and the ODG guidelines, the request for CPT code 97110-physical therapy lumbar spine x 6 sessions, 4 units per sessions is medically necessary for the treatment of this patient's new on the job injury.

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)