

## IRO REVIEWER REPORT

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DATE OF REVIEW: 04/12/2011

IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

2 sessions of post injection physical therapy (lumbar spine)

### 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 2 sessions of post injection physical therapy (lumbar spine) are not medically necessary to treat this patient's condition.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 03/31/11
- Letter from attorneys to – 03/31/11
- Decision letter from. – 03/21/11, 03/30/11
- Request for preauthorization by FAX from Dr. – 03/16/11
- Urgent request for pre-authorization for physical medicine and rehabilitation from Dr. – 01/10/11
- Procedure note for epidural steroid injections by Dr. – 02/22/11
- Request for preauthorization of lumbar facet joint injection by Dr.– 02/10/11, 03/10/11
- Office visit notes by Dr. – 03/09/11
- Report of MRI of the lumbar spine – 12/14/10
- Report of electrodiagnostic studies 01/17/11
- SOAP notes by Dr. – 02/14/11
- Report of weight machine exercises – 01/26/11, 02/14/11
- Workers' Compensation Initial Evaluation Report by Dr. – 01/07/11
- Initial office visit notes by Dr. – 02/09/11
- Report of lower extremity electromyography and nerve conduction studies – 01/17/11
- Orthopedic History and Physical by Dr. – 01/26/11

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on xx/xx/xx when the vehicle he was driving was hit from behind while he was sitting still. The patient complains of cervical pain with radicular symptoms down the right upper extremity into the right hand. He also complains of low back and leg pain. The patient has undergone consultations, pain specialist referral and diagnostic testing in the form of both upper and lower NCS/EMG and cervical and lumbar MRI. These tests revealed positive findings. Right L/S1 transforaminal ESI was performed on 02/22/11. Two sessions of post-injection physical therapy to the lumbar spine were requested and denied.

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

ODG guidelines indicate that post-injection therapy should be included in the currently suggested maximum visits and would be to emphasize a home exercise program. The records indicated that this patient has received 12 physical therapy visits in the treatment of his low back injury. This number exceeds the ODG guidelines. There is not sufficient documentation or clinical justification to further exceed the guidelines and allow for the requested 2 post-injection physical therapy visits. In addition, there was at least one physical therapy visit post-injection and on that visit, home exercise instructions could have been given. Therefore, it is determined that the requested 2 sessions of post injection physical therapy (lumbar spine) are not medically necessary to treat this patient's condition.

**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)