MEDRx

3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 4-6-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of 12 visits of physical therapy consisting of 97014, 97010, 97035, 97110, 97530, 97116.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the 12 visits of physical therapy consisting of 97014, 97010, 97035, 97110, 97530, 97116.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties: Group Orthopedic Surgery Group and Center for Sports Medicine.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from included MDR paperwork, utilization letter dated 3-10-2011, utilization

letter dated 3-14-2011, utilization letter dated 3-16-2011, peer review report dated 3-8-2011, peer review report dated 3-14-2011, fax request for physical therapy from Orthopedic Surgery Group and Center for Sports Medicine dated 3-7-2011, order requisition, records from Orthopedic Surgery Group and Center for Sports Medicine 11-22-2010 through 3-4-2011, Prium pre-authorization 12-9-2010, peer review report dated 3-2-2011, MRI and xray lumbar spine 12-28-2009.

Records from Orthopedic Surgery Group and Center for Sports Medicine included records 1-6-2010 through 3-4-2011, MRI dated 11-12-2010, Specialty Hospital surgical report dated 10-6-2010, and Laboratories report dated 4-12-2010.

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was injured onxx/xx/xx . He sustained a twisting back injury. He has a prior history of having undergone an anterior L4-5 fusion in 1998. This was shown on the xx/xx/xx dated lumbar MRI, which also revealed a moderate L3-4 stenosis and bilateral foraminal stenosis at L4-5, along with a grade 1 spondylolisthesis at L4-5. He has been previously approved for 15 physical therapy visits for treatment of low back pain. A 2/7/11 dated record from the attending physician (a Dr.) indicated that the claimant was status post ESI that was associated with a worsening of pain. The claimant also had an updated 11/12/10 MRI that revealed an L4-5 moderate broad left disc extrusion. This reviewer also assessed the MRI reports from the aforementioned dates. The claimant was noted to be neurovascularly intact. On 3/4/11, the claimant was noted by the physical therapist to have mild low back pain with occasional left buttock radiation, no issues with walking or stair climbing, mild spasm and tenderness at the paravertebral muscles. There was some motion limitation noted, intact motor (5/5) and reflexes, and, a negative straight leg raise. Twelve additional visits have been requested. Prior attending physician (including from a Dr.) and therapy records from 2010 were reviewed from the Orthopaedic Group and Center for Sports Medicine. Diagnoses as of 4/12/10 included post-laminectomy syndrome, radiculopathy, intractable pain and chronic opiod use, along with HNP at L4-5. A therapy discharge summary indicated that despite the claimant's having been educated with a home therapy program, it was the therapist's opinion that he had "not been compliant" with that program. The home therapy program was reviewed between the therapist and the claimant. Denial letters indicate that he claimant has not provided documentation that ongoing formal supervised therapy is reasonably required any longer.

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

The most recent records have not provided a valid rationale that supports as to why any remaining rehabilitation could not be performed within the context of a prescribed and self-administered protocol. There is not a severity of motion, strength, spasm, edema or gait-

associated issues that would support a resumption of therapy. Finally, the claimant has been well versed in a prescribed and independent therapy program.

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)**