



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 02/25/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 Sessions of Physical Therapy for the Lumbar Spine

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

Board Certified in Orthopaedic Surgery
Certified in Evaluation of Disability and Impairment Rating -
American Academy of Disability Evaluating Physicians

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.

12 Sessions of Physical Therapy for the Lumbar Spine – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- ReCheck/Electrodiagnostic Studies, 02/10/05
- Evaluation, 01/22/07, 06/11/07, 12/10/07, 03/10/08, 06/09/08, 08/11/08, 09/29/08, 10/27/08, 12/15/08, 03/23/09, 03/30/09, 04/27/09, 08/03/09, 10/26/09, 02/22/10, 03/22/10, 10/25/10, 11/17/10, 11/26/10, 12/13/10, 12/27/10, 01/24/11
- Bone Scan, 11/10/08
- Radiology Report, 03/23/09, 10/25/10
- Lumbar Spine MRI, 05/27/09
- Operative Report, 06/21/10
- Referral for MRI of lumbar Spine, 10/29/10
- Lumbar Spine MRI, 11/22/10
- Referral for EMG, 12/03/10
- Request for TENs Unit, 12/30/10
- Denial Letters, 01/07/11, 01/31/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

Electrodiagnostic studies performed on 02/10/05 show there was no clinical or electrical evidence of active or remote lumbar/lumbosacral radiculopathy on the right, and there was no electrical evidence of peripheral polyneuropathy. The diagnosis was hip contusion and “problems with loosening of the hardware had been ruled out”. A repeat evaluation in 2008 demonstrated recurrent discomfort in the hemipelvis without specific findings. A bone scan at that time was negative. Despite any progressive objective findings Dr. requested a repeat MRI in early 2009 and it was obtained 05/27/09 which demonstrated multilevel degenerative findings including a protrusion at L1-L2 that Dr. advocated was the source of his ongoing problems. He had residual soreness in October 2009 and by February 2010 Dr. performed an L4-L5 epidural injection which did not change the patient’s symptoms. A repeat MRI in November of 2010 demonstrated progressive degenerative changes. A repeat EMG in 2010 demonstrated that the patient had diabetic neuropathy. Further physical therapy had been requested.

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

The 12 sessions of physical therapy are neither reasonable nor necessary. The patient has participated in copious physical therapy in the past dating back at least 11 years, without sustained improvement. In addition, the myofascial massage recommended is a passive therapy not recommended by the ODG. The ODG does not endorse physical therapy for chronic pain. Therefore the 12 sessions of physical therapy for the lumbar spine are not medically reasonable and necessary.

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)**
- AMA GUIDES 5TH EDITION**