

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 01/05/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 9 visits over 3 weeks

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

The TMF physician reviewer is board certified in anesthesiology and pain management 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 physical therapy 9 visits over 3 weeks is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 12/28/10
- Decision letter – 12/08/10, 12/15/10
- Report of CT scan of the CT spine – 02/22/01
- Report of MRI of the lumbar spine – 09/30/00
- Letter of physical examination by Dr. – 07/06/09, 10/01/10, 12/13/10
- Letter of follow up examination by Dr. – 12/16/08 to 12/01/10
- Letter to from Utilization Management – 12/29/10
- Report of review – 07/14/09
- Preauthorization request by Dr. – no date
- Response to Pre-Authorization by Professional Reviews – 03/20/09
- PEER Review Report – 08/27/09
- Response to Pre-Authorization by – 12/08/10, 12/15/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx resulting in pain and injury to his lower back and gluteal region. The most recent office visit notes indicate that the patient has had an acute exacerbation of his symptoms with pain to the lower back and radiating down the lower extremity to the toes. The patient has been treated with medications and a home exercise program. The physician indicates that the patient has not responded to his daily exercise program and has recommended that the patient receive physical therapy 9 visits over 3 weeks.

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

This patient suffers from low back pain after a xx/xx/xx injury. Medications and exercises have been utilized for treatment and a home exercise program is in place. Per ODG guidelines, the physical therapy program has been provided and there have been 12 visits in 2006. The physical therapy has exceeded ODG guidelines. A home exercise program is in place and should be continued during the exacerbation of the chronic pain.

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)