

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97110 Addtl Post Op Physical Therapy Lumbar/Cervical x 12 Sessions; 97140 Myofascial Release Therapy Lumbar/Cervical x 12 Sessions; G0283 Electric Stimulation Lumbar/Cervical x 12 Sessions; 97140 Joint Mobilization Therapy Lumbar/Cervical x 12 Sessions

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

MD, Board Certified Family Practice

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Utilization review determinations, 04/20/11, 05/16/11

Office visit note 07/22/10, 08/17/10, 11/09/10, 12/07/10, 09/14/10, 10/19/10, 12/08/10, 01/03/11, 01/04/11, 01/12/11, 01/27/11, 02/08/11, 02/09/11, 03/01/11, 03/15/11, 03/16/11, 03/18/11, 03/21/11, 03/21/11, 03/22/11, 03/24/11, 03/31/11, 04/05/11, 04/11/11, 04/20/11, 05/10/11, 05/11/11

Reconsideration for physical therapy 05/09/11

Procedure note 03/28/11

Radiographic report 08/20/10, 02/23/11

Operative report 08/25/10, 02/25/11

Letter of medical necessity undated

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xxxx. On this date the patient twisted to the right and fell hurting her neck, low back and mid back. The patient reports a prior lumbar injury with laser discectomy in 2002. The patient underwent cervical spine surgery on 02/13/08, revision lumbar spine surgery with fusion and EBI transmitter on 08/25/10. Note dated 11/09/10 indicates that she will begin postoperative physical therapy. The patient subsequently underwent a course of physical therapy. The patient underwent removal of bone growth stimulator with examination under anesthesia on 02/25/11. Office visit note dated 03/15/11 indicates that the patient is ambulatory, carrying her cane with no antalgic gait. On physical examination of the neck and upper extremities reveals deep tendon reflexes are equal and symmetric with no gross motor deficits or paresthesias, negative compression test. Physical examination of the low back and lower extremities reveals mild paravertebral muscle spasm, negative extensor lag, no sciatic notch tenderness, negative flip test bilaterally, negative Lasegue's, negative Braggard's, equal and symmetric DTRs and no

gross motor deficits. The patient underwent bilateral L3-4, L4-5 and L5-S1 medial branch block on 03/28/11. Note dated 04/11/11 indicates that the patient continues to complain of pain in the neck and a burning feeling in her low back. The note indicates that the patient has completed 8 sessions of postoperative physical therapy.

Initial request was non-certified on 04/20/11 noting that it is not clear why postoperative therapy would be performed for a surgery 8 months ago. It is also not clear why cervical therapy would be provided at this time. The denial was upheld on appeal dated 05/16/11 noting that there is no medical necessity for postoperative rehab when the surgical procedure was so remote. The patient has previously completed a comprehensive course of both aquatic and land, based rehab. The nature and mechanism of the reported exacerbation is not described or documented. An increase in pain complaints is not an indication for restarting supervised rehab.

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

This patient underwent revision lumbar surgery on 08/25/10. The patient subsequently underwent a course of aquatic and land based physical therapy. It is unclear why additional postoperative physical therapy for the lumbar spine is being requested at this point when the surgical intervention was performed approximately 10 months ago. The patient's compliance with a home exercise program is not documented. The requested physical therapy is reportedly to treat an exacerbation; however, the nature and extent of the exacerbation is not provided. It is unclear why physical therapy to the cervical spine is being requested at this time. There are no specific, time-limited treatment goals provided. Additionally, ODG does not support the utilization of modality G0283 for the patient's diagnoses. Given the clinical records reviewed, the request for 97110 Addtl Post Op Physical Therapy Lumbar/Cervical x 12 Sessions; 97140 Myofascial Release Therapy Lumbar/Cervical x 12 Sessions; G0283 Electric Stimulation Lumbar/Cervical x 12 Sessions; 97140 Joint Mobilization Therapy Lumbar/Cervical x 12 Sessions is not found to be medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)