



Specialty Independent Review Organization  
**Notice of Independent Review Decision**

**DATE OF REVIEW:** 5/2/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of an additional nine sessions of physical therapy for the lumbar area at The Ortho Spine Clinic.

**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 Physical Medicine and Rehabilitation. The 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 prospective medical necessity of an additional nine sessions of physical therapy for the lumbar area at The Ortho Spine Clinic.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient was injured almost x years ago when she tripped while at work. She has undergone management with medication, PT, ESI, oral analgesics, ACDIF at C5-6, C6-7, lumbar fusion at L2-3 and L3-4, post-operative PT, injections, and chronic pain management program (CPMP) in 2007.

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

After undergoing extensive treatment previously documented for an injury that took place almost x years ago, an additional nine sessions of physical therapy for the lumbar area at Clinic is recommended by the treating doctor.

Per the ODG, the physical therapy program is recommended.

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8)

Medical Treatment: 10 visits over 8 weeks

Post injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks.”

The documentation reviewed states that the patient has been authorized to undergo post-procedural PT (30 sessions of post-surgical lumbar PT and 10 sessions of CPMP).

The documentation of the number of visits that the patient actually participated in was not provided for this review. The documentation of a functional response to treatment was not provided for this review either.

There are no recent notes that document functional status. Only clinical signs and symptoms are documented. In fact, Dr. notes clearly states that return to work status is not addressed during his visits. Furthermore, there is a proposal for SI injections, facet injections, hardware injections, and a potential SCS trial for symptomatic relief and diagnostic work up.

Given that the patient has already been authorized to have extensive PT, a CPMP, lack of documentation of functional response to treatment, lack of documentation of utilization of a home exercise program or carry through, and a recent proposal for several more lumbar/sacral injections, the requested services are not medically necessary at this time.

**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)