



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 10/5/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Physical Therapy lumbar spine x 10-12 sessions over 8 weeks and Therapeutic activities lumbar spine x 10-12 sessions of 8 weeks (97110 & 97530).

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 disagrees with the previous adverse determination regarding the prospective medical necessity of Physical Therapy lumbar spine x 10-12 sessions over 8 weeks and Therapeutic activities lumbar spine x 10-12 sessions of 8 weeks (97110 & 97530).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
DC

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Group: letter – 9/19/11; AR-CMI IRO Summary – 9/19/11; DWC1 – 7/22/11; Associate Statement – 7/29/11; Health System Admission Records – 7/23/11, Various Emergency Department Records – 7/23/11, Disposition Summary – 7/23/11; Rehab Office Note – 8/1/11; Denial Letters – 8/26/11 & 9/7/11; Total Physical Therapy Pre-auth Request – 8/23/11,

Office Note – undated; Prescription – 8/22/11; and Rehab Reconsideration request – 8/30/11.

Records reviewed from DC: Office Notes – 9/7/11.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xxxx the worker was injured on the job during the course of his normal activities. While standing upright, dollying up a trailer, he suddenly had pain in his right lower back and hip region. On xx/xx/xxxx he awoke with much worse pain in the back radiating to the right thigh. On that day he went to Emergency Department in Texas. He filled out a pain diagram depicting pain in the right lower back extending into the right thigh anteriorly and posteriorly. He was treated with analgesics and was released to his home with a 10 day prescription for tapering oral prednisone, with a diagnosis of sciatica and lumbar region disc disorder. Recommendation was made for follow-up at the Medicine Clinic in one week.

On xx/xxxx an Employers First Report of Injury or Illness form was submitted along with an Associate Statement – Workers' Compensation. Each document listed that the injury occurred while dollying gear on a trailer.

On August 1, 2011 Dr. noted that the injured worker presented on that day with continued symptoms. No physical examination findings were discussed. Dr. requested a functional capacity evaluation and physical therapy, 10-12 visits over eight weeks.

On August 11, 2011, the worker was seen at Total Physical Therapy. The worker reported that he had an episode back pain and right lower extremity pain four months previously, successfully treated with injections. The therapist formulated a plan of treatment, but no treatment was authorized or performed.

A prescription for Physical Therapy Evaluation and Treatment, three times per week for two weeks, was submitted on August 22, 2011 on a form from Hospital in Texas.

On August 23, 2011 the request for six physical therapy sessions therapy was non-authorized. On September 7, 2011 a request for reconsideration pertaining to 10-12 supervised rehabilitation sessions was non-authorized. One reviewer commented about some discrepancies in the clinical records.

On September 7, 2011. Dr. submitted a Doctor's Report together with worksheets and forms filled out by the staff and by the injured worker. The worker again wrote that the injury occurred while dollying up a trailer.

He reported right lower back pain radiating into the right lower extremity, interfering with normal activities. Based upon the history and the physical examination findings Dr. diagnosed 846.0 sprain/strain of the lumbosacral region.

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

The injury was reported promptly. The diagnosis was established at the time of the initial visit to the hospital emergency department. The nature of the injury was documented in the Employers First Report of Injury or Illness form and in the Associate Statement – Workers' Compensation form as well as in the history form filled out by the injured worker on xx/xx/xxxx. Discrepancies pertaining to the history of the injury did not appear in records generated by the injured worker.

According to the ODG guidelines the requested procedures are authorized for the diagnosis of lumbosacral strain. In the ODG Treatment Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 09/21/11)

- In the section on Codes for Automated Approval pertaining to diagnosis code 846.0, in the ICD9-CPT Crosswalk UR Advisor, the Bill Review Payment Flag is a Green Flag procedure, denoting that the procedure 97110 (Therapeutic exercises) is authorized, with a mean number of 9.66 visits and with 11 treatments in the 75th percentile.. The procedure code 97530 (Therapeutic activities) is also a Green Flag procedure with a mean number of 7.47 sessions. And with 9 treatments in the 75th percentile.
- In the Procedure Summary section pertaining to Physical therapy (PT):
 - a. Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial.
 - b. Lumbar sprains and strains (ICD9 847.2): 10 visits over 8 weeks

The patient meets the ODG criteria; therefore, the requested service is medically 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)