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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 12/29/11

**IRO CASE #:**

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

Physical therapy twice a week for four weeks to include CPT codes 97110, 97140, and 97010

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

Board Certified in Orthopedic Surgery

### **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.

Physical therapy twice a week for four weeks to include CPT codes 97110, 97140, and 97010 - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluation with (no credentials provided) dated 04/12/11  
Evaluation with (no credentials provided) dated 04/13/11  
Physical therapy notes dated 04/21/11, 05/04/11, 05/10/11, 05/18/11, 05/23/11, 06/08/11, and 06/14/11  
A Utilization Review Determination from dated 06/23/11  
Evaluations with M.D. dated 10/17/11 and 12/05/11  
Order requisitions dated 10/17/11 and 12/05/11  
Physical therapy evaluation with P.T. dated 11/09/11  
A Utilization Review Determinations from dated 11/16/11 and 11/30/11  
A request for preauthorization dated 12/07/11  
A letter from addressed to Professional Associates, IRO dated 12/15/11  
The Official Disability Guidelines (ODG) – Low Back – Lumbar & Thoracic were provided

### **PATIENT CLINICAL HISTORY**

On 04/12/11, Ms. recommended physical therapy for right SI joint dysfunction and right sciatic sprain. On 04/13/11, Mr. recommended therapy once a week for four to six weeks. She received manual therapy that day. On 04/21/11, 05/04/11, 05/10/11, 05/18/11, 05/23/11, 06/08/11, and 06/14/11, the patient attended therapy and received manual therapy, neuromuscular reeducation, and therapeutic exercises. On 10/17/11, Dr. evaluated the patient. She had bilateral low back pain with no numbness or tingling. X-rays that day showed a left superior shift of the pelvis and mild scoliosis of the thoracolumbar spine. A McKenzie evaluation was recommended. On 11/09/11, Ms. recommended therapy once to twice a week for four to eight visits. On 11/16/11, M.D. on behalf of provided non-authorization of the requested physical therapy twice a week for four weeks to include CPT codes 97110, 97140, and 97010. On 11/30/11, M.D. on behalf of also provided a non-authorization of the requested physical therapy. On 12/05/11, Dr. again recommended physical therapy two to three times a week for four to six weeks. Dr. office requested preauthorization for physical therapy on 12/07/11. On 12/15/11, stated in their letter that the request for physical therapy was outside of the recommendations of the ODG.

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

According to the reviewed documentation, the patient has had 11 sessions of physical therapy. The patient complains only of lower back pain with radiation to the right posterior superior iliac spine. She has no neurological findings. The documentation of 11 physical therapy sessions with no clear documentation as to any exceptional factors, other than pain, for continuing beyond the ODG has not been provided. Therefore, in the absence of supporting documentation, there is no objective evidence to supersede the recommendations of the ODG. Therefore, the requested physical therapy twice a week for four weeks to include CPT codes 97110, 97140, and 97010 is neither reasonable nor necessary as it

exceeds the ODG recommendations. The previous adverse determinations should be upheld 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 AND KNOWLEDGE BASE
- 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)