



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision
IRO REVIEWER REPORT TEMPLATE -WC

Date notice sent to all parties: 07/02/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar/cervical physical therapy twice a week for six weeks to include CPT codes 97001, 97002, 97112, and 97140

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal 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 medical necessity exists for each of the health care services in dispute.

Lumbar/cervical physical therapy twice a week for six weeks to include CPT codes 97001, 97002, 97112, and 97140 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

reports from M.D. dated 02/08/12, 03/14/12, and 04/06/12
Lumbar CT scan dated 03/06/12 and interpreted by M.D. Cervical and lumbar MRIs dated 03/06/12 and interpreted by Dr. Physical therapy referral dated 03/14/12 and 04/06/12 and from Dr. Summary of 03/14/12 appointment dated 03/15/12
Physical therapy evaluations dated 03/23/12 and 05/07/12 from P.T.

Physical therapy notes 03/25/12, 04/03/12, 04/05/12, 04/10/12, 04/12/12, 04/18/12, 04/19/12, 04/24/12, 04/26/12, 05/07/12, 05/09/12, 05/15/12, and 05/17/12

Utilization review determinations from xxxxx dated 05/11/12 and 05/31/12

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 02/08/12, Dr. examined the patient. He had a history of laminectomy and fusion at L4 and L5. The diagnoses were degeneration of the thoracic or lumbar intervertebral disc, cervicgia, and pain in the thoracic spine. A CT scan of the lumbar spine dated 03/06/12 revealed an L5-S1 laminectomy and fusion with grade II anterolisthesis of L5 upon S1 and moderate to severe foraminal stenosis. There was mild spondylosis at L2-L3 and L3-L4 with mild spinal stenosis. A cervical MRI dated 03/06/12 revealed disc protrusions at C4-C5, C5-C6, and C6-C7 with mild spinal stenosis and foraminal narrowing at C4-C5 and C5-C6 with associated straightening of the cervical lordosis. Dr. noted the thoracic MRI was normal on 03/06/12. Dr. reevaluated the patient on 03/14/12. The studies were reviewed. Physical therapy twice a week for six to eight weeks was recommended for core stability and neck isometrics. The diagnoses were cervical spondylosis without myelopathy, lumbosacral spondylosis without myelopathy, and post laminectomy syndrome of the lumbar region. Ms. examined the patient in therapy on 03/23/12 and therapy twice a week for six weeks was recommended. The patient attended therapy on 03/25/12, 04/03/12, 04/05/12, 04/10/12, 04/12/12, 04/18/12, 04/19/12, 04/24/12, 04/26/12, 05/07/12, 05/09/12, 05/15/12, and 05/17/12. He received therapeutic exercises and manual therapy. On 04/06/12, Dr. asked the patient to return as needed, as he did not have a surgical answer for his pain. Ms. reevaluated the patient in therapy on 05/07/12. Additional therapy was recommended twice a week for six weeks. On 05/11/12, M.D., on behalf of xxxxx, provided an adverse determination for the requested physical therapy. On 05/31/12, D.O., also on behalf of xxxxx, provided another adverse determination for the requested physical therapy.

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

The patient has had an appropriate course of physical therapy, as he has received 13 sessions based on the documentation provided for review at this time. At this time, the ODG would endorse that the patient would be on a home exercise program and utilizing over-the-counter analgesics and anti-inflammatory medication. Further physical therapy would not be endorsed by the ODG, as it recommends 10 visits over 8 weeks for the lumbar spine and 9 visits over 8 weeks for the cervical spine. Clearly, the claimant has exceeded these recommendations with the therapy provided thus far. The patient had a minor slip and fall injury with no evidence of physiological change to the body. The patient has a preexisting lumbar fusion and decompression. The medical records do not indicate any significant condition for which further physical therapy would be reasonable or necessary either in the cervical or the lumbar spines. Therefore,

the requested lumbar and cervical therapy twice a week for six weeks to include CPT codes 97001, 97002, 97112, and 97140 is neither reasonable nor necessary and 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 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)