

Notice of Independent Review Decision

**DATE OF REVIEW:** 12/02/2013

**IRO CASE #:**

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

Physical Therapy 3x Wk x 3Wks Cervical, Low Back 97110x2 97124 G0283 97035x2

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

The TMF physician reviewer is board certified in physical medicine and rehabilitation with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

**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.

It is determined that the physical therapy 3x Wk x 3Wks Cervical, Low Back 97110x2 97124 G0283 97035x2 is not medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 11/12/13
- Decision Letter – 08/12/13, 09/25/13
- SOAP notes – 04/30/13 to 06/06/13
- Copy of ODG – TWC Integrated Treatment/Disability Duration Guidelines Neck and Upper Back (Acute & Chronic) - 05/14/13

- Copy of ODG – TWC Integrated Treatment/Disability Duration Guidelines Low Back – Lumbar & Thoracic (Acute & Chronic )– 10/09/13
- Letter to TMF – 11/16/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on xx/xx/xx resulting in pain and injury to his cervical and lumbar spine. The patient has been treated with medications, chiropractic visits and physical therapy. The patient is described as having minimal improvement and still complains of stiffness throughout all planes of motion and constant pain. There is a request for the patient to undergo a continuation of physical therapy at 3x Wk x 3Wks.

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

Rather than further physical therapy, the ODG guidelines and the North American Spine Society (NASS) clinical practice guidelines recommend redirecting this patient's treatment algorithm to further diagnostic workup utilizing, but not limited to, MRI, CT myelogram and or diagnostic interventions such a discography. Further physical therapy is not warranted.

**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)

North American Spine Society (NASS) clinical practice guidelines for cervicalgia and lumbago.