



MedHealth Review, Inc.  
661 E. Main Street  
Suite 200-305  
Midlothian, TX 76065  
Ph 972-921-9094  
Fax (972) 827-3707

## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 2/12/14

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of 10 PT sessions (2x/week for 5 weeks) with CPT codes 97035, 97110, and 97530.

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

The reviewer is a Doctor of Chiropractic who is board certified in Chiropractic. The reviewer has been practicing for greater than 21 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 2 PT sessions with CPT codes 97110, and 97530.

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of 8 PT sessions with CPT codes 97110, and 97530. The reviewer agrees with all 10 sessions of 97035 being denied as not medically necessary per the ODG.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed: 1/23/14 letter of medical necessity, 8/26/10 DWC 69

report, 1/4/10 report, 2/25/09 lumbar MRI report, 3/12/09 lumbar procedure report, and 1/8/14 office note.

1/13/14 preauthorization appeal letter, 1/23/14 assignment letter, 1/8/14 preauth letter, 5/15/13 SOAP note, 4/20/11 lumbar MRI report, 4/18/11 lumbar MRI script, 6/3/11 operative report, 1/13/14 denial letter, 1/16/14 denial letter, LHL 009, 1/10/14 report, 1/15/14 report, and 1/23/14 letter.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves an injured worker who was injured xx/xx/xx. She has undergone 10 sessions of physical therapy, chiropractic, chronic pain management, ESI, and medicinal management. The most recent lumbar MRI shows foraminal narrowing, bilateral facet arthrosis, and disc bulging at L4/5 with foraminal narrowing, disc bulging, and spondylosis at L5/S1. An ESI was performed in June 2013. All of the above care was provided prior to June of 2013. She was placed at MMI with a 5% lumbar impairment rating in August of 2010. During the latest visit in January of 2014, the injured worker complains of 'severe' lumbar pain with radicular symptoms into the left leg. The exam in January of 2014 indicates the injured worker is antalgic with reduced left patellar reflex and positive lumbar orthopedic findings. is requesting 10 sessions of PT which has been denied by the carrier.

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

It appears that the patient has performed through 10 of the 12, ODG recommended sessions of physical therapy for sciatica symptoms. The study by Tulder et al indicates that "The review of trials found strong evidence that exercise therapy is not more effective than inactive treatments or other active treatments for acute low back pain. However, exercise therapy was found to be more effective than usual care by general practitioners for chronic low back pain." During the reviewer's search for exacerbation guidelines in the ODG, there was little to no indication of there being any direction provided. However, the above study is "The highest quality evidence of all, based on the ODG ranking system, is a systemic review or meta-analysis (rated 1 in ODG), such as a Cochrane Systematic Review, that combines the results of multiple clinical trials.

The ODG also indicates that a trial of physical medicine may be necessary to determine effectiveness. Therefore, the two remaining sessions of physical therapy are approved while the remaining 8 are denied based upon the ODG.

**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) Tulder MW van, Malmivaara A, Esmail R, Koes BW  
Exercise therapy for low back pain: a systematic review within the framework of the Cochrane collaboration back review group, Spine 2000 Nov 1;25(21):2784-96
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)