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Notice of Independent Review Decision

DATE OF REVIEW: 7/1/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of physical therapy 1x6 for the lumbar spine.

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 Chiropractic.

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 agrees with the previous adverse determination regarding the medical necessity of physical therapy 1x6 for the lumbar spine.

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:

Denial of appeal request for PT sessions – Claims – June 4, 2014
Peer Review Report – Claims – 06/02/14

Pre-authorization appeal – 05/28/2014
IRO Notice of Assignment – 06/12/2014
Peer Review Initial –Insurance – 05/05/2014
Medical Review – 05/05/2014
Initial Pre-authorization request – 04/30/2014
IRO Request – 06/06/2014
Pre authorization request appeal letter – 06/17/2014
TWCC Form 69 – 07/22/2010
IR and MMI determination summary letter – 07/22/2010

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

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the available medical records, the patient is a male who was injured on the job when he slipped and fell. He injured his thoracic and lumbar spine and both feet. He has been diagnosed with neuritis, myalgia, and lumbar disc disorder, lumbar neuralgia, compression fractures of thoracic spine, compression fractures of lumbar spine, fractures of metatarsals, fracture of talus, deconditioning, and atrophy. He has undergone surgeries for his spine and foot fractures and to have a morphine pump placed. The pump became infected and it had to be removed. The patient has a permanent disability rating of 23% from previous designated doctor ratings and final diagnosis codes of 805.8, 825.25, and 824.8 on 07/22/2010.

The reported ICD-9 diagnosis codes currently diagnosed from injury are:

Neuritis, myalgia, Lumbar disc disorder, Lumbar neuralgia/radiculitis, compression fractures thoracic spine, compression fractures lumbar spine, fracture of metatarsals, fracture of talus, de-conditioning and atrophy. CPT requested -97110, 97112, and 97530

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

ODG guidelines state that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. He has already attended 18 sessions of PT since 8/2013. His injuries are work related, however, evidence based guidelines do not support continued physical therapy for chronic back pain.

- I. REFERENCES: ODG Treatment Guidelines; Physical therapy guidelines; Low back pain chapter, exercises

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)