

Notice of Independent Review Decision

DATE OF REVIEW: 02/23/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97110 Addtl Physical Therapy Lumbar Spine 2xwk x 8 wks, 97039 Physical Therapy Lumbar Spine 2xwk x 8 wks, 97112 Neuromuscular Reeducation Lumbar Spine 2xwk x 8 wks, 97113 Aquatic Therapy Lumbar Spine 2xwk x 8 wks, 97124 Massage Therapy Lumbar Spine 2xwk x 8 wks, 97140 Manual Therapy Lumbar Spine 2xwk x 8 wks, 97530 Therapeutic Activities Lumbar Spine 2xwk x 8 wks.

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

The TMF physician reviewer is a board certified Internal Medicine physician 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 97110 Addtl Physical Therapy Lumbar Spine 2xwk x 8 wks, 97039 Physical Therapy Lumbar Spine 2xwk x 8 wks, 97112 Neuromuscular Reeducation Lumbar Spine 2xwk x 8 wks, 97113 Aquatic Therapy Lumbar Spine 2xwk x 8 wks, 97124 Massage Therapy Lumbar Spine 2xwk x 8 wks, 97140 Manual Therapy Lumbar Spine 2xwk x 8 wks, 97530 Therapeutic Activities Lumbar Spine 2xwk x 8 wks is not medically indicated to treat this patient's condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when a xx ran into her several times injuring her low back and mid back. Lumbar MRI showed right foraminal disc herniation with mild narrowing of the right neural foramen at L3-L4, diffuse disc herniation by approximately 3 mm causing mild narrowing of spinal canal and bilateral neural foramina at L4-L5, and diffuse disc herniation causing mild narrowing of spinal canal and bilateral neural foramina. MRI Thoracic Spine was unremarkable. The patient has received physical therapy previously and has been receiving pain management since May 2013. There is a request for the patient to receive 97110 Addtl Physical Therapy Lumbar Spine 2xwk x 8 wks, 97039 Physical Therapy Lumbar Spine 2xwk x 8 wks, 97112 Neuromuscular Reeducation Lumbar Spine 2xwk x 8 wks, 97113 Aquatic Therapy Lumbar Spine 2xwk x 8 wks, 97124 Massage Therapy Lumbar Spine 2xwk x 8 wks, 97140 Manual Therapy Lumbar Spine 2xwk x 8 wks, 97530 Therapeutic Activities Lumbar Spine 2xwk x 8 wks.

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

While there is some evidence that the proposed modalities can provide benefit for acute low back pain, there is no indication for their use in this case. The patient has already undergone a course of physical therapy during the acute phase of her injury. The medical literature and ODG guidelines do not support the use of these types of modalities for an injury that is more than two years old. It is beyond a degree of medical probability that the proposed treatment would provide substantial benefit for this patient.

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 KNOWLEDGBASE
- 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)