TMF
Health Quality Institute

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Notice of Independent Review Decision

DATE OF REVIEW: **12/10/12**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97750 Physical Performance Test/Meas W/Reprt Ea 15 min

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

The TMF physician reviewer is a licensed chiropractor 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 97750 Physical Performance Test/Meas W/Reprt Ea 15 min was not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 11/27/12
- Explanation of Review – 08/22/12
- Amended Explanation of Review – 10/19/12
- Request for an IRO – 11/20/12
- Request for Reconsideration – 09/21/12, 09/26/12
- Initial Medical Report – 03/20/12

- Office visit notes – 03/21/12 to 08/16/12
- Subsequent Medical Report – 05/07/12
- Report of Functional Capacity Evaluation – 07/11/12
- Letter of Medical Necessity – 07/11/12
- Report of Peer Review – 08/02/12
- Report of MRI of the lumbar spine – 06/18/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when she was helping in moving and pushing. This resulted in pain to her lower back that has gotten worse with pain radiating down her left leg. An MRI of the lower spine revealed a 3.5 to 4mm central bulge at L5-S1. The patient underwent a Functional Capacity Evaluation on 07/11/12. The insurance carrier has denied payment for the Functional Capacity Evaluation.

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

This patient was evaluated on 03/20/12 and given a DWC73 returning her to work without restrictions on 03/21/12. She was to be referred to another doctor for evaluation. She had 6 chiropractic and therapy sessions which revealed some improvement but no mention of work status is seen. A subsequent medical report is dated 05/07/12 indicating her pain down her left leg has gotten worse. No mention if she had seen the other doctor. There was no mention regarding off work notice and no DWC73 was seen in the notes for this time period. Essentially the same treatment plan was continued for an additional 6 visits with the last visit on 07/05/12. A subsequent medical report is not available after the 6 additional visits. During the time frame, a lumbar spine MRI was performed on 06/18/12 and nothing in the notes indicates the results. Nothing is mentioned about ordering an FCE which was performed on 07/11/12. A letter of medical necessity dated 07/11/12 provides generic information about a FCE but no specific clinical justification was given as to why this specific patient needed an FCE. The letter states the FCE needs to be done to establish baseline of functions and physical demand level and to evaluate the progress of the injured worker. Since she was released to return to work without restrictions and then nothing else in the records to show she was taken off of work, there was no need for an FCE. The initial visit, the 12 chiropractic and the therapy sessions with a subsequent medical report gave the doctor ample opportunity to determine these factors without the need for the FCE. Records show 4 additional chiropractic and therapy visits ranging from 07/25/12 through 08/30/12. These all show improvement subjectively, however, other aspects of the notes are very similar. There is no mention of work status in these notes. Therefore, it is determined that the 97750 Physical Performance Test/Meas W/Report Ea 15 min was not medically necessary to treat this patient's condition.

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)**