IRO REVIEWER REPORT– WC

DATE OF REVIEW: 2-19-2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CPT: 97110; 97530; 97140; 97112; 97035 / Physical Therapy 3 times 4 weeks

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

Doctorate of Physical Therapy

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/ adverse determinations should be:

X 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.

Injury Date	Review Type	Services Being Denied	Claim #	Dates	Upheld Overturn
	preauth	97110		12-26-2006	Upheld
	preauth	97530		12-26-2006	Upheld
	preauth	97140		12-26-2006	Upheld
	preauth	97112		12-26-2006	Upheld
	preauth	97035		12-26-2006	Upheld
	preauth	97110		1-4-2007	Upheld
	preauth	97530		1-4-2007	Upheld
	preauth	97140		1-4-2007	Upheld
	preauth	97112		1-4-2007	Upheld
	preauth	97035		1-4-2007	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Independent Review Organization Summary dated 2-7-2007
Compensation Work Status Reports 7-18-2006 – 1-18-2007
Review Determinations of 1-4-2007, 12-26-2006, 8-23-2006, 8-15-2006
Physical Therapy Notes 10-30-2006 to 12-15-2006
History & Physical dated 12-6-2006
XXXX signed 12-19-2006
Notice of Disputed Issue(s) & Refusal to Pay Benefits dated 8-24-2006
Associates Statement – Workers Compensation dated 8-3-2006
Statement of Treatment on 7-17-2006
Physician Summaries dated 7-18-2006 & 12-15-2006

PATIENT CLINICAL HISTORY:

According to the information received, was driving on in route from the home store to another work facility location, when claimant struck another vehicle. The claimant injured the neck, mid-back and lumbosacral spine regions. Physician examination on 7-18-2006 revealed some range of motion restriction of the cervical and lumbar spine. There was diagnosis of lumbar radiculopathy to the left, cervical disc displacement, thoracic spine pain, cervical, thoracic and lumbosacral spine: pain, spasms and weakness. The physician stated that claimant medically qualified for modified / light duty work status on the date of 6-18-2006 until further notice. Recommended physical rehab/therapy-medically qualified for 18 treatments / sessions.

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

In light of previous 18 physical therapy sessions, the additional physical therapy sessions 3x/week are not medically necessary for this claimant. Although the claimant has been 100% compliant and has demonstrated objective strength and range of motion improvements, there is no evidence of existing functional limitations or opportunity for functional improvements. It is clear, for example, that the right shoulder abductors improved in strength from a manual muscle test grade of $4^{-/0}$ on 7-18-2006 to a grade of 4^{+} on 12-15-2006.[1] However, it is unclear how the current muscle strength is limiting function, or how the improvement in muscle strength has correlated to improved function with specific activities of daily living or work-related activities. Documented demonstration of such improvements in function or current limitations in function would demonstrate necessity for continued physical therapy. A validated clinical outcome measure would have been indicated to demonstrate change/improvement in function. For example, the Oswestry Disability Index is a ten-section questionnaire that covers aspects of daily living that may be affected by back pain.[2] Additionally, the documentation did not include any objective or measurable goals to track progress or clarify direction and need of continued physical therapy.

Also, per the Required Medical Examination performed on 12-6-2006, the physical exam findings did not indicate medical necessity for continued physical therapy. Overall range of motion and strength were found to be within normal limits. The abnormal findings included tenderness to palpation at the lumbar spine, a positive Faber's test bilaterally, and positive Straight leg Raise with dorsiflexion bilaterally. These results alone do not warrant the need for additional physical therapy 3x / 4 weeks after prior 18 visits and exercise program.

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[1] Re-examination results provided on 12-15-2006

[2] Fairbanks JCT, Davis JB, Couper J, O'Brien JP. "The Oswestry Low-back Pain Disability Questionaire." Physiotherapy. 1980;66(8):271-3

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**
- X **MEDICAL JUDGMENT, 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**
- X **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**