

Notice of Independent Review Decision

DATE OF REVIEW:

10/15/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Physical Therapy three times per week for six weeks pertaining to thoracic/lumbar strain consisting of 4 units of therapeutic exercise, 4 units of therapeutic activities, 1 unit of manual therapy, 1 unit neuromuscular re-education and 4 units of aqua therapy.

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

Board Certified Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME

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

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.

The request for outpatient Physical Therapy three times per week for six weeks pertaining to the thoracic /lumbar strain consisting of 4 units of therapeutic exercise, 4 units of therapeutic activities, 1 unit of manual therapy, 1 unit of neuromuscular re education and 4 units of aqua therapy is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old female who twisted her mid and lower back xx/xx/xx with no evidence of neurological compromise and a normal MRI and the standard x-ray was also normal. The patient received physical therapy and was placed on a home exercise program and aqua therapy. Physical examination of the patient from 05/22/08 to 08/18/08 indicates no improvement in range of motion of the lower and mid back. She has had one evaluation by the therapist, two water therapies and one physical therapy treatment. She did not go to continued therapy sessions initially since he wanted to change therapy locations secondary to issue of hygiene in the prior therapy location. The neurological exam has remained normal. She had been authorized on 06/23/08 for ten previous physical therapy (PT) sessions.

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

The underlying cause of the medial complaints is given as a chronic strain/sprain of the thoracic and lumbar area that occurred xx/xx/xx. The injured individual was authorized for ten previous PT sessions on 06/23/08 which is the amount considered reasonable for this condition per guidelines of OTG – TWG under lower back and mid back area indicated ten visits for this condition. The Official



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Disability Guideline (ODG) provides a general guideline of three to four units/session (45-60 minutes of therapy). There is no other data to support other diagnosis.

The injured individual is still symptomatic and has not done well with medications and home exercise. Her general stiffness over the months is essentially the same. Based on the documentation provided, she has had one physical therapy treatment, two aquatic therapy treatments and one physical therapy evaluation. She had been to previous PT sessions authorized on 06/23/08.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES