

Clear Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 25, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of additional physical therapy.

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity does not exist for additional physical therapy.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female injured on xx/xx/xx when she was thrown from a snowmobile. Initial injury was reported to the right ankle and knee. A 10/05/07 MRI of the lumbar spine showed L4-5 mild loss of disc space height with mild effacement of the anterior thecal sac and there was mild bilateral facet arthrosis with minimal impingement of the bilateral neural foramina. At L5-S1 there was near complete loss of disc space height and disc desiccation with bilateral facet arthrosis causing impingement of the left L5 nerve more than right.

On 11/15/07 Dr. saw the claimant for a designated doctor examination (DDE). He noted that she had no fractures at the time of injury. He noted that the claimant had some knee pain since injury and had minimal ankle pain. She reported that she was having

pain in her back that was not mentioned or treated before. On examination there was pain of the sacral and sacroiliac (SI) joints. There was a negative straight leg raise with a normal neurological examination. He felt she had reached maximal medical improvement with the ankle and knee but that she needed treatment for the low back.

The claimant was seen on 05/15/08 by Dr. for a DDE for complaints of pain in the lower abdomen, right knee and right ankle as well as low back pain. On examination straight leg raise caused low back pain bilaterally. He reported she had good lumbar motion and reflexes were 2 plus with no sensory deficits.

On 06/18/08 Dr. evaluated the claimant and noted the claimant had a right knee arthroscopy in 04/07 and had grade 4 tricompartmental debridement with incomplete relief after surgery. She reported low back pain radiating to the buttocks with a feeling of weakness on the right. The claimant was taking DayPro. On examination straight leg raise caused hamstring discomfort. Neurologically she was intact. Fabere's was positive bilaterally. The impression was axial low back pain, possible SI joint component, severe loss of disc height at L5-S1 and possible radicular irritation. Therapy, epidural steroid injection (ESI) and medication were the recommendations. The claimant was evaluated by physical therapy on 07/02/08. Visits through 07/22/08 indicated that there was no substantial change in pain. On 07/22/08 Dr. saw the claimant for Dr. and noted that pain persisted despite therapy and radiated into the left buttock to the knee. On examination there was pain with flexion and extension. The neurological status was intact. Facet loading on the left increased pain. An ESI and medication were recommended.

On 07/24/08 Dr. saw the claimant noting that she had medications, therapy and a TENS and her overall response was unchanged. Pain affected all activities of daily living. She also noted that she had ongoing low back, right knee and right ankle pain. On examination there was full ankle motion and strength with no swelling or crepitation. There was no knee effusion, the knee was stable with some patellofemoral pain and negative McMurray. Motion was 0-130 degrees. The claimant was unable to toe and heel walk. She had no spasm and normal reflexes and sensation. Straight leg raise was positive bilaterally at 45 degrees and back motion was limited.

He felt that she had not reached Maximum Medical Improvement in regard to her back. A 08/06/08 note from Dr. indicated that after an epidural steroid injection the back and radicular pain were 60 percent better. He noted that the claimant had 8 visits of therapy for her back that had been helpful and she wanted more. Additional therapy has been denied times 2 on peer review.

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

The treatment proposed relates to an injury from xx/xx. It appears from the medical records that 40 visits of physical therapy have already been provided. The treating physician has suggested that only 8 of these were for the back. When one turns to the Official Disability Guidelines, 10 visits of physical therapy can be approved over an 8 week course for lumbar sprains and strains. However, given the passage of over 1 ½ years since this injury, this claimant is clearly outside of the 8 week window. This much time after a strain there should be no lingering difficulty. As such, it would be difficult to explain how additional physical therapy would make any functional difference. The reviewer finds that medical necessity does not exist for additional physical therapy.

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)