



Medical Review Institute of America, Inc.
America's External Review Network

Amended Review: 1/19/09

DATE OF REVIEW: January 19, 2009

IRO Case #:

Description of the services in dispute:

Denied for medical necessity: Items in dispute: Physical Therapy 3 times per week for 4 weeks.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The clinician who provided this review is a licensed Physical Therapist. This reviewer is a member of the American Physical Therapy Association. This reviewer has been in active practice since 2003.

Review Outcome

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

Upheld

The patient's periods of exacerbation are not uncommon, and should be able to be handled with a home program and use of self techniques to decrease spasms/pain. Thus, Physical Therapy 3 times per week for 4 weeks is not medically necessary.

Information provided to the IRO for review

FROM THE STATE OF TEXAS:

Request for IRO 12/17/08 - 6 pages
Letter from Dr. 11/21/08 - 2 pages
Letter from Dr. 12/15/08 - 2 pages
Letter 12/19/08 - 1 page
Letter 12/22/08 - 1 page
IRO instructions - 1 page

FROM THE REQUESTOR:

Patient intake forms 12/19/08 – 8 pages

FROM THE INSURANCE COMPANY:

ODG–TWC Disability Guidelines – 7 pages

Preauthorization request – 1 page

MRI lumbar spine report 10/31/08 – 2 pages

PT evaluation/treatment form 11/10/08 – 1 page

Letter 11/10/08 – 1 page

PT treatment plan 11/10/08 – 1 page

OT reevaluation 11/14/08 – 2 pages

Chart notes 11/25/08 – 2 pages

Evaluation summary – FCE 11/25/08 – 8 pages

Report of medical evaluation 12/3/08 – 1 page

Chart notes 12/4/08 – 1 page

OT reevaluation 12/5/08 – 3 pages

Letter of reconsideration 12/8/08 – 2 pages

PT evaluation/treatment form 12/9/08 – 1 page

UR Department 12/9/08 – 1 page

Request for reconsideration 12/11/08 – 1 page

Letter 12/29/08 – 2 pages

Confirmation of receipt of request for IRO 12/19/08 – 1 page

Patient clinical history [summary]

The patient is a male who sustained a thoracic/lumbar injury on xx/xx/xx. The patient presented with chief complaints of low back pain with associated spasms, limiting tolerance to work duties. MRI was positive for small left paracentral protrusion of disc material at L5–S1 without definitive basis for compromise of the nerve roots. The patient has undergone 9 therapy visits with positive outcomes, pain rating of 1/10 on re–evaluation on 11/14/08; improved strength, improved ROM, and demonstrates understanding of proper body mechanics. The patient was taught a program to continue at home, and demonstrated ability to maintain progress made. During the FCE on 11/25/08, the patient experienced exacerbation of symptoms, which lead to a decrease in ROM and strength during the 12/5/08 re–evaluation.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The patient made good progress with therapy with increased motion and strength. The patient has good understanding of the home program demonstrated by ability to maintain progress during a period of no therapy. The patient was instructed on proper lifting techniques and should be able to

implement them in his daily activities. Given the findings on the MRI, periods of exacerbation are not uncommon, and should be able to be handled with a home program and use of self techniques to decrease spasms/pain.

Based on the ODG guidelines, the original 9 visits should have allowed for decreased pain, increased function and teaching for independence in management of progression, and how to handle any episodes of exacerbation without further injury.

A description and the source of the screening criteria or other clinical basis used to make the decision:

ODG- Low Back- Lumbar and Thoracic Guidelines

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