



Notice of Independent Review Decision

DATE OF REVIEW: 11/30/10

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for physical therapy services, three times a week for two weeks consisting of therapeutic exercise, electrical stimulation (e-stim), message and a home exercise program (HEP).

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

Texas Licensed Physical Medicine and Rehabilitation Physician.

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 previously denied request for physical therapy services, three times a week for two weeks consisting of therapeutic exercise, electrical stimulation (e-stim), message and a home exercise program (HEP).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Dispute Letter dated 10/13/10.
Radiology Report dated 9/28/10.
Letter for Reconsideration dated 10/28/10.
Pre-Authorization Request dated 10/19/10.
Progress Report dated 10/18/10.
Order Sheet dated 10/8/10.
WC Visit dated 10/8/10, 10/1/10, 9/21/10, 9/14/10, 9/9/10.
Radiology Report dated 9/28/10.
SOAP Sheet dated 10/8/10-9/13/10.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx
Gender: Male
Date of Injury: xx/xx/xx
Mechanism of Injury: Driving a car and sitting on a defective seat.
Diagnosis: Sprain Lumbar Region

This male sustained an injury on xx/xx/xx. The mechanism of injury was related to driving a car and sitting on a defective seat. The diagnosis made to date included lumbosacral strain. The data that was reviewed included physical therapy notes and physician's notes, as well as MRI reports. A previous note from Dr. date 9/09/10 revealed the patient had a negative straight leg raise (SLR) and the diagnosis of lumbosacral strain. Initial physical therapy notes, dated 9/13/10, noted that the patient was requested for therapeutic exercise, massage including electrical stimulation, hot packs and cold packs. In the week of 9/27/10 it was reported that the patient had a mild pain on Wednesday and Friday of that week. An MRI report, dated 9/28/10, revealed minimal impingement of the thecal sac at the level of L4-5 and L5-S1 with no other findings. On 9/30/10, on Thursday of that week, the physical therapy noted indicated the patient reported mild pain. The patient was noted to have had at least nine visits of physical therapy. A note dated 10/8/10 from the treating physician, Dr., noted that the patient had stiffness in the back, lumbar spasm, and reduced ROM. The neurologic examination included knee jerk, which was normal. There was no motor examination done. There were no other reflexes noted. It was also noted that the patient had no acute distress. The patient was on non-steroidal anti-inflammatories. In the last office visit dated 10/18/10, it was noted that the patient had reduced range of motion (ROM) of the lumbosacral spine on flexion 45 degrees, extension 10 degrees, and side bending of 20 degrees. No manual muscle testing was noted. A visual analog score was not included or noted. It was noted in the physical therapy notes that the patient had reduced pain and improved ROM after physical therapy.

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

Based on the data reviewed, this reviewer upheld the decision for the previously denied request for physical therapy, three times a week for two weeks. The

Official Disability Guidelines (ODG) was referenced in reviewing this case. In particular in the lumbar section, the ODG, under Physical Therapy Guidelines, Web Based for the “lumbar sprains and strains, 10 visits over 8 weeks” is recommended. It was also noted under the ODG-Physical Therapy Guidelines recommend to “Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT.” In this particular case, there was no self-directed home physical therapy program that was initiated. As well, under the Physical Therapy Guidelines, it was noted that a home program should be initiated within the first therapy session and must be ongoing assessments of compliance, as well as upgrades to the program. The ODG also states, “The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes.” Regarding the request for a TENS unit, the ODG indicates that a TENS unit is “not recommended as an isolated intervention...may be considered as a noninvasive conservative option for chronic back pain, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration...” Based on the data reviewed, it appears that the patient had a lumbosacral strain and improved with nine visits of physical therapy. The patient was treated by an internist. There was no referral to a specialist. There were no outliers noted to suggest that the patient was actually getting worse. There was no documentation of motor findings or sensory findings. The patient was noted to have a negative straight leg raise (SLR). Based on the data observed, continuation of therapy decision that was reached is upheld on the previously adverse determination request.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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 AND 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).