



Notice of Independent Review Decision

DATE OF REVIEW:

09/14/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy two times a week for two weeks.

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

Board Certified Chiropractor

REVIEW OUTCOME

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

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 medical necessity for physical therapy two times a week for two weeks is established upon review of the documentation.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 09/01/10 MCMC Referral
- 08/30/10 Independent Review Organization Summary,
- 08/30/10 letter from, IRO Coordinator,
- 08/27/10 Notice To MCMC, LLC Of Case Assignment, , DWC
- 08/27/10 Notice Of Assignment Of Independent Review Organization, , DWC
- 08/26/10 memo from Supervisor,
- 08/26/10 Confirmation Of Receipt Of A Request For A Review, DWC
- 08/20/10 Review Outcome notice,
- 08/18/10 Request For A Review By An Independent Review Organization
- 08/17/10 Treatment Plan
- 08/16/10 Review Outcome notice,
- 08/11/10, 08/17/10 Pre-Authorization Fax Cover Sheets, Healthcare & Rehabilitation
- 08/03/10 C-spine radiographs, Medical Center
- 08/03/10 Return To Work PPE, Diagnostic Inc.
- 07/28/10 lumbar spine radiographs, Medical Center
- 07/28/10 Patient Registration Form, Medical Center
- 07/28/10 chart note, Medical Center
- 07/27/10, 07/22/10, 08/10/10, 08/24/10 Work Status Reports, , D.C.
- 07/22/10 office note, Healthcare & Rehabilitation
- 07/22/10 to 08/10/10 handwritten chart notes, Healthcare Rehabilitation (some of poor quality)
- 07/21/10 Job Offer – Temporary Alternative Duty
- 07/20/10 Employers First Report of Injury or Illness
- 07/20/10 Worker's Compensation Request For Medical Care

- 07/20/10 Associate Statement – Workers' Compensation
- 07/20/10 Work Status Report, M.D., DWC
- Undated, handwritten chart note, M.D.
- Home exercise sheets, Chiropractic and Rehabilitation
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

Records indicate that the injured individual is a female who was reportedly injured as a result of an occupational incident that occurred on xx/xx/xx. The records indicate that the above captioned individual reported that she was putting trash bags into a compactor. The bags reportedly weighed up to 50 pounds. She reports the onset of neck and back pain after this incident on xx/xx/xx. She presented for care on 07/22/2010 complaining of neck and back pain. Ranges of motion were reduced. X-rays were negative for significant pathology. She was treated and released for modified work duty. To date, she has completed a course of physical therapy (PT) to include at least six sessions.

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

The Official Disability Guidelines (ODG) allows for a six session course of PT for the condition of record to test for objective and/or functional improvement. The injured individual presented to the office of the attending provider (AP) on 07/22/2010 with pain levels of 9/10 and ranges of motion severely reduced. By comparison, on 08/03/2010, a physical performance evaluation was performed and showed that the injured individual reported non-exertion pain levels of 7/10 and lumbar ranges of motion were in some areas sharply increased from the initial examination. As such, there would be reasonable expectations that the requested course of care would demonstrate additional subjective, objective and/or functional increases. Moreover, the demonstration of the minimal increases in objective deficits and minimal increases in subjective pain levels would satisfy the guidelines of the ODG. As such, the requested course of continuing care would be consistent with the ODG and certified as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Physical Therapy Guidelines –

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. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial".

Lumbar sprains and strains (ICD9 847.2): 10 visits over 8 weeks

Sprains and strains of unspecified

There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of



managing care. managing claims.

88 Black Falcon Avenue, Suite 353 Boston, MA 02210 (T) 800-227-1464 (F) 617-375-7777

treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.