

SENT VIA EMAIL OR FAX ON
Aug/04/2011

Applied Resolutions LLC

An Independent Review Organization
900 N. Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063
Phone: (214) 329-9005
Fax: (512) 853-4329
Email: manager@applied-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Physical Therapy 3 X 4, 97110 X 2, 97140 97112 Lumbar

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

Board Certified PMR

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Cover sheet and working documents
2. Utilization review determination dated 07/11/11, 07/20/11
3. Office visit note dated 06/08/11, 06/15/11, 06/29/11, 07/13/11
4. MRI lumbar spine dated 07/18/11
5. Lumbar spine evaluation dated 06/08/11, 06/29/11
6. Soap notes dated 06/15/11-06/22/11, 06/24-07/01/11, 07/05/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was lifting a heavy pipe and noted low back pain. Initial physical examination on 06/08/11 noted deep tendon reflexes 2/4 in the bilateral patellar tendons. There is pain to palpation of the lumbar L4-5 spinous interspace. The patient subsequently completed 9 sessions of physical therapy. Physical examination on 07/13/11 noted 2/4 deep tendon reflexes and right lumbar paraspinal pain. MRI of the lumbar spine dated 07/18/11 revealed disc protrusion/extrusion in the right paracentral/foraminal location at L5-S1 with L5 nerve root impingement as well as S1 nerve root impingement on the left; there is disc desiccation with loss of disc height noted at this level along with bilateral foraminal narrowing due to hypertrophy of the facet joint. Degenerative disc disease is also noted at L4-5 with moderate facet arthropathy and

ligamentum flavum hypertrophy contributing to mild central canal stenosis, mild to moderate neural foraminal stenosis with abutment of the exiting L4 nerve root at the neural foraminal level bilaterally.

Initial request for additional physical therapy 3 x 4 was non-certified on 07/11/11 noting that ODG supports up to 9 sessions and the request exceeds this recommendation. There are no exceptional factors noted in the documentation. The denial was upheld on appeal dated 07/20/11 noting there is no objective documentation regarding compliance and response to a home exercise program. The number of requested visits on top of the previous therapy sessions is deemed in excess of the recommendation of guidelines.

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

Based on the clinical information provided, the request for additional physical therapy 3 x 4, 97110 x 2, 97140, 97112 lumbar is not recommended as medically necessary. The patient has completed 9 sessions of physical therapy to date. The Official Disability Guidelines support up to 9 sessions for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. There are no specific, time-limited treatment goals provided. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program as recommended by the ODG.

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

ACOEM-AMERICA 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)