Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 1/28/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of 12 sessions of physical therapy.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of 12 sessions of physical therapy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
Orthopaedic Surgery Group.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: order requisition form 11/30/10, certificate of medical necessity 12/23/10, office notes by Dr. 10/6/10 to 1/3/11, 10/21/10 lumbar MRI report and 11/4/10 to 11/18/10 PT progress notes.

1/10/11 letter by MD, ODG PT guidelines, 1/6/11 email from 11/10/09 denial letter and report from DC, 10/29/10 order requisition form, undated letters indicating injury during training from, 12/10/10 denial letter and report by MD, 12/10/10 email from Deliveryware and 10/25/10 to 11/18/10 PT progress notes.

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available records, this individual is a female who injured her lower back while working on xx/xx/xx. The first treatment record is dated October 6, 2010 and is from her treating physician, M.D. Dr. noted the injury and stated that the injured worker had taken a Medrol Dosepak. She had been having transient left thigh and leg pain, but at the time of this dictation on October 6, that leg pain had resolved. She was still complaining of back discomfort. Dr. documented good range of motion of the spine, negative straight leg raise, no spasms, and minimal tenderness. He diagnosed a lower back pain syndrome and sprain of the lumbar region. He recommended continuation of modified work duty with no lifting at the fire station, Naprosyn, initiation of physical therapy as soon as possible, and follow-up in four weeks.

An MRI of the lumbar spine performed on October 21, 2010 showed mild dextroscoliosis of the lumbar spine with no evidence of spinal stenosis. There was a mild disk bulge at the L4-5 level with mild bilateral foraminal narrowing. There are eight physical therapy notes contained in this record. The first note was provided on October 25, 2010 by P.T. Mr. noted that the injured worker was currently asymptomatic and stated that her lumbar derangement was stable and she did not have pain production with any direction of lumbar movement. On October 27, Mr. stated that the injured worker had not had any symptoms for several days and was making steady progress.

On October 29, Dr. stated that the patient did not have signs of radiculopathy. She was neurovascularly intact and had minimal tenderness. Straight leg raise was negative, and her range of motion was improved. He recommended continuation of therapy, Naprosyn, and work modification. Records indicate that the injured worker completed her physical therapy program on November 18, 2010. At that time, her pain level was 1 to 2/10 and she was said to be independent in her home exercise program.

On November 30, Dr. documented that the injured worker was performing physical therapy and making good improvement, but would like to continue with therapy. The last note from Dr. is dated January 3, 2011. In that note, he stated that the injured worker was doing well and wanted to return to regular duty. She had had several episodes of transient back pain, but Dr. stated that these were becoming less frequent. He noted minimal tenderness, negative straight leg raise, and that the injured worker was neurovascularly intact. He recommended return to work and continuation of Naprosyn.

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

Available medical records indicate that this worker injured her back while performing a lifting activity at work on xx/xx/xx. She was treated with Medrol Dosepak and modified duty. Also, according to available medical records, she received 12 physical therapy sessions. Records indicate that she made excellent progress in the therapy sessions. There is documentation that she was asymptomatic on many occasions and having only transient episodes of discomfort when she was last evaluated by her treating physician on January 3, 2011. Her physical therapist indicated that she was independent in her home exercise program when she received her last physical therapy session on November 18, 2010.

ODG Treatment Guidelines recommend ten physical therapy visits over an eight week period for a lumbar sprain. Records indicate that this individual received 12 physical therapy sessions and was released from physical therapy with minimal tenderness and occasional discomfort and independence in a home exercise program. She has received the treatment recommended by the ODG Treatment Guidelines and there is no indication in the medical record that she would benefit from further physical therapy or that there is a medical necessity for further physical therapy. Therefore, she does not meet the criteria for further physical therapy as established by the ODG Treatment Guidelines.

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)**