

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 02/23/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Physical Therapy x6 sessions

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

Texas Board Certified General Surgeon
Texas Board Certified Internal Medicine

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a xx year old female who sustained an injury when she lifted an object.

A peer review performed 11/15/10 stated the MRI of the lumbar spine performed 05/10/09 revealed small disc protrusion at L4-L5 and L5-S1 without compromise of the spinal canal or neural foramina. This report was not submitted for review.

The employee was seen for evaluation on 09/30/10. The employee complained of persistent neck and back pain with decreased range of motion. Physical examination reveals decreased neck and lumbar range of motion. The employee is assessed with cervical and lumbar sprain. The employee is recommended for physical therapy. The employee is seen for physical therapy evaluation on 01/04/11. The employee complains of pain in the right hip, lower thoracic spine, and lumbar spine, rating 2 to 8 out of 10. Current medications include Aleve and Ibuprofen. The employee reports daily muscle spasms and sleep disturbance. Physical exam reveals sensation is intact throughout. The reflexes are 2+ throughout. Right straight leg range of motion is to 74 degrees. The employee is recommended for 6 sessions of physical therapy.

The request for physical therapy is denied by utilization review on 01/11/11. The note stated the request appeared excessive and not medically reasonable without additional medical data.

The employee was seen for physical therapy on 01/24/11. The employee had attended a total of five sessions. The employee reported decreased pain from 7 out of 10 to 3 out of 10. Right straight leg raise range of motion had increased from 74 degrees to 83 degrees. The employee demonstrated upper abdominal strength. The employee was recommended for six additional sessions of physical therapy to assist with increasing right hip strength.

The request for physical therapy x 10 sessions was denied by utilization review on 02/11/11 as the employee was status post ten physical therapy visits and should be proficient with the use of a home exercise program at this juncture of treatment.

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

The request for physical therapy x10 sessions is not recommended as medically necessary. There is no documentation regarding significant functional improvement that would warrant additional physical therapy outside of the amount recommended by current evidence-based guidelines. Additionally, the employee did not exhibit any exception functional limitations that would warrant continuation of physical therapy. The employee could reasonably transition to a home exercise program to address the minor functional limitations noted on physical examination. As such, medical necessity is not supported.

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

1. ***Official Disability Guidelines***, Online Version, Neck and Upper Back Chapter
2. ***Official Disability Guidelines***, Online Version, Low Back Chapter