

# I-Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jul/18/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

12 Physical Therapy visits to Lumbar spine

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

MD, Board Certified Orthopedic Surgery

**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**

Official Disability Guidelines

Utilization review determination dated 05/27/11, 06/17/11

Patient daily progress report dated 04/15/11, 04/12/11, 04/14/11, 04/07/11, 04/06/11, 03/31/11, 03/30/11, 03/24/11, 03/22/11

Handwritten physician progress note dated 06/13/11, 05/19/11, 04/21/11, 04/06/11, 02/28/11, 02/24/11, 02/15/11, 01/12/11, 12/08/10, 11/03/10, 10/06/10, 09/07/10, 07/13/10, 06/10/10, 05/11/10, 04/13/10, 03/23/10, 02/16/10, 01/07/10, 12/03/09, 11/12/09, 11/03/09, 10/14/09, 09/15/09, 09/10/09, 07/23/09, 06/11/09, 04/30/09, 06/08/10, 09/01/09, 08/19/09, 08/05/09, 07/23/09, 06/23/09, 06/09/09, 05/28/09, 05/12/09, 04/29/09, 04/07/09, 03/25/09, 03/10/09, 03/03/09, 02/24/09, 06/24/10, 03/25/10

Radiographic report dated 03/23/11

MRI lumbar spine dated 05/06/11, 03/09/09

RME dated 02/02/11, 03/18/10

Designated doctor evaluation dated 02/03/10

Letter dated 01/07/10

Office visit note dated 12/10/09

History and physical dated 11/10/10

Orthopedic follow up report dated 09/16/10, 08/19/10, 11/12/09, 09/10/09, 07/22/10, 06/24/10

Intake form dated 07/07/06

Previous review dated 05/27/11, 06/28/11

Physical therapy evaluation dated 05/23/11, 06/08/11

Designated doctor evaluation dated 08/26/09

Operative report dated 08/21/09

MRI right hip dated 06/15/09

CT scan right hip dated 06/25/09  
Electrodiagnostic interpretation dated 04/14/09  
Calibration certificate dated 06/08/11, 03/10/11  
Handwritten intake form dated 06/18/11

#### **PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was attempting to repair a bathtub valve when he felt a sharp pain in his lower back. MRI of the lumbar spine dated 03/09/09 revealed multilevel disc disease primarily at L4-5 and L5-S1; spondylitic and degenerative arthritic changes. Electrodiagnostic study dated 04/14/09 revealed evidence consistent with bilateral L3-5 radiculopathy with radiculopathy involving right S1 nerve root as well.

The patient underwent L5-S1 bilateral medial branch block and right sided SNRB on 08/21/09. Designated doctor evaluation dated 08/26/09 indicates that the patient has been treated with physical therapy which did not help. Diagnosis is lumbar radiculopathy. The patient has not reached MMI but is expected to on or about 11/26/09. RME dated 03/18/10 indicates that future treatment should include office visits every four months for medical care and medication, possible epidural steroid injection or laminectomy/discectomy at L5-S1. Follow up note dated 06/24/10 indicates that the patient underwent right L4-5 and L5-S1 minimally invasive microdiscectomy on 04/30/10. RME dated 02/02/11 indicates that there is no need for any ongoing chiropractic modalities, formal physical therapy, work hardening or work conditioning programs. MRI of the lumbar spine dated 05/06/11 revealed moderate neural foraminal narrowing on the right at L3-4 and bilaterally at L5-S1 with contact of the associated exiting nerves. Physical therapy evaluation dated 06/08/11 indicates that the patient completed 9 sessions of PT from 03/22/11-04/15/11. On physical examination the patient ambulates with a pronounced antalgic gait. There is extreme tenderness to palpation in the lumbar spine bilateral of midline, worse on the right. Lumbar range of motion is decreased in all planes. Sensation is decreased on the left along the L5 and S1 dermatomes. Muscle strength is decreased in the bilateral lower extremities. Achilles deep tendon reflexes are 1+/4 on the right and 2+/4 on the left.

Initial request for physical therapy was non-certified on 05/27/11 noting that the patient has attended what should have been a sufficient number of PT visits since his injury and surgery and there is no evidence that he has been involved in an ongoing home rehab program. No objective evidence of improvement from therapy has been submitted for review. The denial was upheld on 06/17/11 noting that guidelines recommend up to 10 visits and the patient has been authorized for 12 visits. There are no exceptional factors to warrant additional sessions. Guidelines do not support use of passive modalities of 97032 and 97035.

#### **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 12 physical therapy visits to lumbar spine is not found by the reviewer to be medically necessary. The patient most recently has completed 9 sessions of physical therapy. The Official Disability Guidelines support up to 10 visits 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 is no comprehensive assessment of the patient's objective, functional response to the most recent therapy submitted for review to establish efficacy of treatment and support additional sessions. Additionally, ODG does not support the utilization of modalities 97032 and 97035 for the patient's diagnosis.

**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)