

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/21/2011

**IRO CASE #:**

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

12 additional sessions of physical therapy for the lumbar spine

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

M.D., Board Certified in Physical Medicine and Rehabilitation

**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  
Determination dated 04/12/11  
Determination dated 04/29/11  
Prescription from Dr. dated 03/15/11  
Physical therapy evaluation dated 03/15/11  
Physical therapy treatment records 03/15/11, 03/22/11, 03/29/11, 04/06/11, 04/12/11  
Discharge summary dated 05/19/11

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a XX year-old female who is reported to have sustained a work related injury to her low back on XX/XX/XX. The claimant has apparent diagnosis of lumbar strain. There is a prescription for physical therapy dated 03/15/11. On 03/15/11 the injured employee was evaluated by PT. It is reported the injured employee works as an employee for specified agency. On the date of injury she was assisting a client near a vehicle when the door closed on her back. She has had back pain since then. She is noted to have had 13 visits of physical therapy from 12/27/10 through 02/03/11 with good results. Notes describe PT being discontinued by insurance company before the patient was fully recovered. She is now reported to have exacerbation of her symptoms. She is reported to have low back pain with radiation down the right lower extremity into the calf. Her typical pain levels are 5-10/10 with work activities. On physical examination she is noted to have full motor strength in right lower extremity and slightly diminished strength in left hip flexors, knee extensors, 4 to 4+ in knee flexors, ankle dorsiflexors, plantar flexors and great toe extensors. She is reported to have 50% reduction in range of motion with exception of right side bending. Her Achilles reflexes are absent bilaterally. The left patellar reflex was absent. The right is reported to be 1+. She is reported to have positive slump test on left and painful straight leg raise on left. Records indicate the injured employee received physical therapy through 05/19/11 in which she was discharged. She was noted to have 5 to 5- strength in left upper extremity, lumbar flexion was improved to 75%, remaining range of motion is 100%, pain levels are 2/10, and

she has decreasing abnormal sensation. Her straight leg raise is to 85 degrees bilaterally and pain free. Her Oswestry Disability Index improved to 10. A request for 12 sessions of physical therapy was submitted on 04/12/11. The reviewer non-certified the request noting that additional physical therapy was not reasonable and necessary and in excess of the ODG guidelines. The submitted clinic note from Dr. dated 03/15/11 provided no justification to support 12 additional sessions. It is reported that a peer to peer consultation occurred.

The appeal request was reviewed on 04/29/11. The reviewing physician denies the appeal request noting there is no reasonable justification for documents submitted for further physical therapy beyond home directed program, and there is no indication that effort was made to fade treatment. Peer to peer contact was not made.

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

The request for 12 additional sessions of physical therapy for lumbar spine is not medically necessary. The available data indicates the claimant sustained an injury to her low back on XX/XX/XX when a door closed on her low back. She was diagnosed with lumbar strain. She received 13 visits of physical therapy from 12/27/10-02/03/11 and had apparently returned to work. Current evidence based guidelines would support up to 10 sessions of physical therapy for diagnosis of lumbar strain. There are no clinical records submitted from the provider which would validate the presence of lumbar radiculopathy or other extenuating circumstances that would warrant additional physical therapy beyond what is recommended in the guidelines. The previous adverse determinations should be upheld.

**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)