

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: February 28, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 additional sessions of physical therapy

A 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)

The requested service, 12 additional sessions of physical therapy, is not medically necessary for treatment of this patient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 1/24/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 2/4/11.
3. Notice of Assignment of Independent Review Organization dated 2/7/11.
4. Medical records from DO dated 1/6/11, 12/27/10, 12/2/10, 10/27/10, 9/27/10, 7/27/10, 7/8/10, 6/7/10, 5/24/10, 5/7/10, 4/23/10 and 4/9/10.
5. Medical records from MD dated 10/28/10 and 7/12/10.
6. MRI report from Imaging Center dated 5/21/10.
7. Medical Record from Laboratory dated 5/7/10.
8. Texas Workman's Compensation status reports dated 1/6/11, 12/27/10, 12/2/10, 10/27/10, 9/27/10, 7/27/10, 7/8/10, 6/7/10, 5/24/10, 5/7/10, 4/23/10 and 4/9/10.
9. Denial Documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work injury to his lumbar spine on xx/xx/xx while lifting an. The patient reported low back pain and a burning sensation to the low back and occasional tingling sensation to the left lower extremity. An MRI performed in May 2010 revealed a decreased signal intensity of the L2-L3 to L5-S1 intervertebral discs, suggestive of desiccation and a posterior annular tear at the L4-L5 level. On 7/12/10, the neurosurgical provider reported that physical therapy to the lumbar region would be initiated for a duration of four weeks at a frequency of three times per week. In September 2010, the patient reported that he had completed his physical therapy sessions, but his low back pain had returned. A follow-up visit on 10/28/10 with the neurosurgical provider indicated that the suggested treatment plan was for the patient to continue with conservative treatment for his back pain. An additional 12 sessions of physical therapy was requested. The URA has denied this request indicating that the requested physical therapy is not medically necessary for treatment of the patient's lumbar spine pain. Specifically, the URA states that the recommended amount of therapy has been provided and the current physical therapy assessment indicates no change from the initial assessment and with the limited treatment history provided, additional physical therapy cannot be supported.

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

Upon review of the submitted clinical evidence, the requested 12 additional sessions of physical therapy are not medically necessary for this patient. The Official Disability Guidelines (ODG) for lumbar spine injuries support up to 20 sessions of physical therapy over 12 weeks. However, ODG does not support additional physical therapy in cases in which the patient has failed to

make significant progress with prior therapy. The submitted documentation demonstrates that this patient's work restrictions have not changed during the entire time of his treatment. Thus, little or no progress has occurred from the therapy already provided. There must be a reasonable expectation that the treatment will result in measurable progress in order for the therapy to be considered medically necessary. Based on the information provided, there is inadequate evidence that the patient meets this criterion and therefore, the requested 12 additional sessions of physical therapy are not medically necessary.

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)