

SENT VIA EMAIL OR FAX ON
May/11/2011

IRO Express Inc.

An Independent Review Organization

2131 N. Collins, #433409

Arlington, TX 76011

Phone: (817) 405-0875

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy Lumbar X 12 visits

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

Board Certified Chiropractic Examiner

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

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped and fell on ice and hit his right arm. The patient was diagnosed with lumbar sprain and right sprain shoulder and upper arm. Physical examination on 02/15/11 notes that lumbar range of motion is flexion 15, extension 5, bilateral lateral bend is 25 degrees. MRI of the lumbar spine dated 03/09/11 revealed disc desiccation at L5-S1 with 2 mm posterocentral annular disc bulge. There is no evidence of foraminal or spinal stenosis. Follow up note dated 03/11/11 indicates that the patient has completed 9 sessions of physical therapy to date. Right shoulder has been resolved but lumbar pain is prolonging. The patient has returned to work with restrictions. Range of motion is left lateral 10, right lateral 15, flexion 35 and extension 10. Functional capacity evaluation dated 03/24/11 indicates that the patient's required PDL is heavy and current PDL is medium.

Initial request for physical therapy x 12 visits was non-certified on 02/25/11 noting that the submitted documentation was limited and was missing a complete initial history and physical

examination. It is unclear if the claimant has undergone previous physical therapy including how many visits and clinical outcome. The request exceeds Official Disability Guidelines. The denial was upheld on appeal dated 03/18/11 noting the patient has completed a combined total of 10 sessions of physical therapy and has returned to work with restrictions. The patient's current PDL versus required PDL has not been documented.

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 physical therapy lumbar x 12 visits is not recommended as medically necessary, and the two previous denials are upheld. The patient sustained a lumbar sprain on xx/xx/xx when he slipped and fell on ice. The patient has subsequently completed at least 9 sessions of physical therapy, per follow up note dated 03/11/11. The Official Disability Guidelines support up to 10 visits of physical therapy 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. The patient has returned to work. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program as the guidelines recommend. Given the current clinical data, the requested physical therapy is not indicated as medically necessary, and the two previous denials are 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)