Notice of Independent Review Decision

DATE OF REVIEW: 11/01/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 2 x Week x 3 Weeks

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

Board Certified in 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Physical Therapy 2 x Week x 3 Weeks – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The patient injured her low back and elbows on xx/xx/xx when she was cleaning and bent down to pick up a letter opener. She lost her balance and fell back on the concrete. X-rays were obtained, which showed no fractures. She was diagnosed with lumbar strain,

lumbar pain and elbow contusion, right and left. She was referred for physical therapy. She received an initial evaluation for physical therapy with Medical Centers. She was to attend three times per week for two weeks. She then started to treat with Orthopaedic Surgery group for back pain. Apparently an MRI was performed on 08/01/11 which demonstrated some edema; however, no herniated disc. She was diagnosed with lumbar sprain and referred for physical therapy. A second initial evaluation for physical therapy was performed at Orthopaedic Surgery group. She was to be treated two to three times per week for four weeks. On 09/16/11, she had undergone six therapy sessions, indicating the therapy was helping her. Additional therapy was requested and she was prescribed Flector patches.

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

Per the medical information provided for my review, the patient has had at least twelve sessions of physical therapy with the most current 09/26/11 re-evaluation by physical therapy failing to document findings that would support the patient's inability to address any residual deficits with a home exercise program, and Dr. 09/16/11 office note failed to document a rationale why the patient could not perform home exercises to address any residual deficits. ODG for this patient's condition would recommend up to ten visits over eight weeks. At this time the patient has received in excess of that amount with twelve visits to date, and the medical records do not document a rationale that would support the need to further deviate from ODG Guidelines.

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)**
- ☐ **AMA GUIDES 5TH EDITION**