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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/03/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 additional visits of physical therapy for the back

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

M.D., Board Certified 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

Legal correspondence dated 10/13/11

Request for IRO dated 10/13/11

Utilization review determination dated 08/24/11

Utilization review determination dated 09/15/11

Legal correspondence dated 10/19/11

Clinical records D.C. dated 08/08/11

Letter of appeal dated 09/09/11

Request for physical therapy dated 10/03/11

Clinical records Dr. dated 06/22/11, 08/16/11

Clinic note D.C. dated 06/22/11

MRI right shoulder dated 07/13/11

MRI of lumbar spine dated 07/13/11

Clinic notes dated 06/22/11-08/08/11 (physical therapy)

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male injured on xx/xx/xx. He twisted his body and felt a pop in his back and pull in his right shoulder. He was initially evaluated and placed off work. He followed up at the hospital.

On 06/22/11 the claimant sought care from Dr. He is noted to have history of back injury 10 years ago, which required lumbar surgery at L3-4 levels. He is a type II diabetic. He has hypertension. He presented with complaints of pain in low back radiating to right thigh and left knee with accompanied range of motion limitations. On physical examination he is 6'1" tall and weighs 248 lbs. He appears uncomfortable in his chair and holds his hands over his back. He has full cervical range of motion. Examination of the abdomen revealed panniculus adiposus. His abdomen is tender. He has pain from T10 to L5. Left and right straight leg raise arouses pain from T10 to L5. He has tenderness in both knees worse on left. The right shoulder is tender with limited range of motion. Reflexes are 1+ on left lower extremity.

Sensation is decreased from L5-S2 on left. He is reported to have 4/5 strength in L5-S1 level. He is opined to have lumbar strain with pain radiating down both legs and right shoulder strain. He was provided oral medications and referred for 12 sessions of physical therapy.

D.C, initially evaluated the claimant for therapy. On 07/13/11 the claimant was referred for MRI of the right shoulder. There is reported full thickness tear of the distal infraspinatus tendon seen at the attachment to the greater tuberosity of humeral head. There is mild acromioclavicular joint hypertrophy. There is type I acromion without impingement in subacromial space. There is reported tear of biceps labral complex seen. MRI of lumbar spine was performed on this same date. There is severe disc space narrowing. L1-2 and L2-3 are unremarkable. At L3-4 there is a 3 mm annular disc bulge seen flattening the thecal sac. There is bilateral facet arthrosis noted with moderate central canal stenosis. There is mild bilateral foraminal narrowing seen. At L4-5 a left sided laminectomy has been performed. A residual 4 mm annular disc bulge compresses the thecal sac. There is moderate facet joint arthrosis seen with thickening of the right ligamentum flavum. There is severe central canal stenosis noted with flattening of the thecal sac as well as right L5 nerve root sleeves. There is moderate narrowing on left with mild narrowing of right neural foramen noted. At L5-S1 there is a 3 mm subligamentous disc protrusion with radial tear in outer annulus noted with flattening of the thecal sac. There is mild bilateral foraminal encroachment noted. Records indicate the claimant continues to have pain despite having undergone 8 sessions of physical therapy on 08/08/11. It is noted the original request was for 12 sessions, which was verbally approved for 10. He is reported to have only received approval for 3. The submitted clinical records indicate the claimant has undergone 13 sessions of physical therapy between 06/22/11 and 08/08/11.

On 08/16/11 Dr. saw the claimant in follow-up. MRI of the shoulder and lumbar spine were discussed. On physical examination movement arises pain in lower thoracic and lumbar spine radiating to legs. He continues to have pain from T10-L5. Straight leg raise results in pain from T1-L5. He continues to have tenderness in bilateral knees. Right shoulder is tender with limited range of motion. Reflexes are unchanged. Sensory is unchanged. He is to be referred to Dr. for evaluation and continue physical therapy.

Dr. performed the initial review on 08/24/11. Dr. notes that there is no detailed information on injured worker's improvement to include subjective complaints, objective exam findings, and functionality. He noted insufficient information provided to assess the efficacy of therapy, the appropriateness of therapy cannot be ascertained, and he subsequently non-certified the request.

The record contains reconsideration letter from D.C. dated 09/09/11, which indicates the claimant is in acute phase of care due to exacerbation of pain. He indicates the patient has not had any therapy since exacerbation. It is reported on monitored home exercise program that was prescribed by previous treating doctor has been ineffective. He cites previous IRO decision, which references ACOEM Guidelines. A subsequent IRO request for physical therapy was submitted on 10/03/11. It is reported the claimant has had 3 sessions of physical therapy with improvement as shown in current evaluation. His pain levels have decreased and his range of motion has increased, which shows comparison in evaluations dated 06/22/11, 08/08/11. Per this documentation the claimant is reported to have had improvement in right shoulder flexion from 90-110 degrees. Extension has improved from 10 to 25 degrees. Internal rotation has improved 5 degrees. External rotation is illegible. Abduction appears to have improved to 123 degrees, and there has been no change in adduction. The second chart indicates that the claimant received treatment for the cervical spine. If interpreted correctly it would appear to indicate the claimant has lost cervical flexion, improved 10 degrees in cervical extension, improved 5 degrees in left lateral flexion, and 3 degrees in right lateral flexion. A subsequent request was made for 12 additional sessions to fully rehabilitate the patient to pre-injury status.

Dr. performed a subsequent appeal review on 09/15/11. Dr. notes the claimant has completed 10 sessions of physical therapy for the back and that the additional visits would

greatly exceed recommended number of physical therapy visits. She notes the claimant should be transitioned to independent home exercise program.

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

The submitted clinical records indicate the claimant-sustained injuries to his right shoulder and low back as result of work place event. The claimant has sustained a strain injury to low back and there is MR evidence of full thickness tear of distal infraspinatus tendon. It is noted the treating physician Dr. has recommended the claimant be referred to spinal surgeon for evaluation. Given the claimant's treatment plan is in question and response to right shoulder physical therapy while there is improvement, surgical intervention has been recommended to address full thickness tear, and therefore, continued physical therapy would not be clinically indicated. The data presented in the letter of appeal is for cervical spine, yet the claimant was receiving treatment for lumbar spine. Current evidence based guidelines would have supported up to 10 sessions of physical therapy. The claimant has already exceeded that with 13 sessions documented. As such, the request for 12 additional visits of physical therapy for the back is not medically necessary at this time.

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)