

SENT VIA EMAIL OR FAX ON
Oct/18/2011

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 12visits over 4 weeks, left shoulder, low back, right knee

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

PMR

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

OD Guidelines

Cover sheet and working documents

Utilization review determination dated 09/14/11, 10/07/11, 08/18/11, 07/25/11

Encounter notes dated 07/20/11, 07/13/11, 06/28/11, 06/29/11

Peer review report dated 08/12/11

MRI right knee dated 08/16/11

Radiographic report dated 08/16/11, 06/28/11

Letter dated 10/10/11

Preauthorization request dated 09/09/11

Follow up note dated 09/02/11, 08/08/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped in the break room and landed on her knees, left elbow and seat. She primarily complains of low back pain and right knee pain. Encounter note dated 06/28/11 reports assessment of low back strain, right knee contusion and left shoulder strain. MRI of the right knee dated 08/16/11 revealed grade I sprain vs. interstitial degeneration of the proximal posterolateral corner structures, no meniscal tear identified. Follow up note dated 09/02/11 indicates that the patient continues to complain of tenderness at her low back, bilateral shoulder and right ankle joints. On physical examination lumbar range of motion is flexion 26, extension 14, right lateral flexion 15, left lateral flexion 17. There is tenderness to palpation at the lumbar spine. Deep tendon reflexes are +1/2 at the patella and Achilles tendons. There is

decreased sensation along the right L4-5 dermatomal distribution during pinwheel sensory testing. Right knee range of motion is 0-108 degrees.

Initial request for physical therapy was non-certified on 09/14/11 noting that ODG does not recommend utilization of requested modalities including therapeutic ultrasound, and the request for 12 sessions is excessive as ODG supports an initial trial of 6 sessions to establish efficacy of treatment. The denial was upheld on appeal dated 10/07/11 noting that ultrasound is not supported.

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 is not recommended as medically necessary, and the two previous denials are upheld. There is insufficient clinical information provided to support this request. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. It is unclear if the patient has undergone any physical therapy to date. The patient has been diagnosed with sprain/strain injuries which should have resolved with or without treatment given the patient's date of injury. The patient's compliance with an active home exercise program is not documented. Given the current clinical data, the requested physical therapy is not indicated as medically necessary

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)