

# True Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/12/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Physical Therapy 3 X wk X 4 wks 97010 97110X2 97112X2 97140X2 97150 Back

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

Family Practice

**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

1. Cover sheet and working documents
2. Utilization review determination dated 08/19/11, 08/04/11
3. Letter dated 08/05/11, 08/08/11
4. Physical therapy evaluation dated 07/29/11
5. Handwritten note dated 06/27/11
6. Chart cover dated 06/27/11
7. Office visit note dated 05/25/11, 04/20/11, 05/09/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xxxx. On this date the patient fell off a truck while unloading tubes. Note dated 04/20/11 indicates that the patient underwent MRI. Assessment is herniated lumbar disc. Note dated 05/09/11 indicates that the patient has had some mild pain across the lumbar spine, but primarily pain is in his bilateral legs. He has not had physical therapy, but has had 2 chiropractic visits. The patient does not have clear cut pathology for surgery. Physical therapy evaluation dated 07/29/11 indicates that pain is rated as 7/10. On physical examination sensation is intact. Lumbar range of motion is limited.

Initial request for physical therapy was non-certified on 08/04/11 noting that the patient has undergone at least 12 sessions of physical therapy; however, the series of physical therapy progress notes were not submitted for review to objectively determine the patient's progress through the course of therapy. The current number of requested visits on top of the previous

visits undergone has already exceeded the guideline limitation. There is no discussion provided whether the patient has exceptional factors to undergo excess visits. Appeal letter dated 08/08/11 indicates that the patient did not undergo the 12 initial sessions as the Hospital is out-of-network. The denial was upheld on appeal dated 08/23/11 noting that factors of prolonged or delayed recovery should be identified and addressed rather than pursuing continued therapy that provides no complete benefit.

**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 3 x wk x 4 wks 97010 97110 x 2 97112 x 2 97140 x 2 97150 back is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient's compliance with an independent, self-directed home exercise program is not documented. There are no exceptional factors of delayed recovery provided to support a course of physical therapy months after the patient's date of injury. Additionally, the Official Disability Guidelines do not support the utilization of modalities 97010, 97112 or 97150 for the patient's diagnosis and note that no more than four modalities should be utilized per session. 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**

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**