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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 Initial Visits, Physical Therapy, Thoracic Spine/Cervical/Lumbar

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
Utilization review determination dated 05/17/12, 05/30/12
Office visit note dated 06/12/12, 05/23/12, 05/11/12, 04/24/12, 05/01/12
MRI lumbar spine dated 05/30/12
Letter dated 03/23/11
Reconsideration for physical therapy dated 05/24/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date she and another nurse were re-positioning a patient in bed when she reported significant mid and low back pain. Diagnoses are thoracic spine strain/sprain and lumbar spine strain/sprain. Follow up note dated 05/23/12 indicates that the patient presents with a new complaint of bilateral wrist pain which started a few days ago. On physical examination muscle strength testing revealed left EHL grade 4, left tibialis anterior 75% of normal. Upon examination spasms and tenderness were located in the left trapezius, left suboccipital, left lower cervical, left levator scapula, left cervical paraspinal, right trapezius, right suboccipital, right lower cervical, right cervical paraspinal, left rhomboids, left thoracic paraspinal, right rhomboids, right thoracic paraspinal, left lumbar paraspinal, right lumbar paraspinal and right quadratus lumborum muscles. Palpation and examination indicates tenderness and spasms in the left quadratus lumborum muscle. MRI of the lumbar spine dated 05/30/12 revealed L1-2, L2-3 and L3-4 levels are unremarkable. At L4-5 there is a 3 mm disc bulge flattens the thecal sac without foraminal narrowing. At L5-S1 there is a 3 mm disc bulge flattening the thecal sac without foraminal encroachment.

Initial request for 12 physical therapy visits was non-certified on 05/17/12 noting that the requested visits in addition to the previously rendered PT sessions are more than

recommended by the cited criteria. Regarding cervical PT, there was no injury reported to the cervical spine and the diagnoses were mainly noted as thoracic strain/lumbar strain. The medical necessity of CPT code #G0283 is not fully established. Current evidence based guidelines support an initial six visit clinical trial. It is deemed that 6 PT visits for thoracic/lumbar spine with CPT codes 97110, 97140 would be medically appropriate and necessary; however, as the requesting doctor could not be contacted to discuss a partial approval or treatment modification. Reconsideration letter dated 05/24/12 indicates that the patient has not had any therapy since her injury. She was pregnant at the time of the incident and therapy was presumably contraindicated by her previously treating physician. The denial was upheld on appeal dated 05/30/12 noting that there was insufficient documentation to indicate prior conservative treatments initiated to include home exercise program, hot/cold packs or activity modification and efficacy in terms of reducing the patient's pain and increasing function. Guidelines recommend active versus passive treatment modalities as they are associated with substantially better clinical outcomes.

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

Based on the clinical information provided, the request for 12 initial visits, physical therapy, thoracic spine/cervical/lumbar is not recommended as medically necessary, and the two previous denials are upheld. The patient sustained lumbar and thoracic strains approximately one year ago which should have resolved at this time with or without treatment. The Official Disability Guidelines support an initial six visit clinical trial and up to 10 visits for the patient's diagnoses, and there is no clear rationale provided to support exceeding this recommendation. There are no specific, time-limited treatment goals provided and the patient's compliance with a home exercise program is not documented. Additionally, there is no indication that the patient sustained an injury to the cervical spine. 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)