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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/26/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy Lumbar Spine x 9 visits; Neuromuscular Reeducation Lumbar Spine x 9 visits; Massage Therapy Lumbar Spine x 9 visits

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

Board Certified Family Medicine

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

Request for IRO 07/06/12

Utilization review determination dated 06/21/12

Utilization review determination dated 07/03/12

Utilization review determination dated 03/23/12

MRI lumbar spine 05/24/12

Clinic notes Dr. 06/04/12, 06/19/12, and undated partial note

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. It is reported she slipped on wet floor and fell subsequently developing low back pain.

Records indicate the claimant was referred for physical therapy and seen by LPT on 03/06/12. The claimant was provided a partial approval for physical therapy 3 times a week for 2 weeks for total of 6 sessions. On 05/24/12 the claimant was referred for MRI of lumbar

spine. This study notes mild degenerative changes of lumbar spine with disc bulging at L5-S1 level seen without spinal canal stenosis or neural foraminal stenosis. There is reported annular tear at L5-S1. On 06/04/12 the claimant was seen in follow-up by Dr.. She is reported to be symptomatic with ongoing low back pain that radiates to left posterior thigh and associated weakness and tingling. On physical examination she is tender to palpation over the L5-S1 interspace. Paraspinal muscular spasms and decreased range of motion. Straight leg raise is reported to be positive on left. Deep tendon reflexes are 1+ on left and 2+ on right. There is weakness in left quadriceps and posterior tibialis. She was recommended to receive 9 sessions of active physical therapy to include therapeutic exercises, neuromuscular reeducation and manual therapy. There is discussion regarding EMG/NCV studies.

The claimant was seen in follow-up on 06/19/12 and noted to have continued low back pain and spasms aggravated by bending and minimal lifting. She is noted to have slow antalgic gait. She is reported to have decreased lordotic curve. She is tender to palpation over the L5-S1 interspace and paraspinal musculature spasms. Range of motion is decreased in flexion / extension. Neurologic examination indicates positive straight leg raise on left, decreased Deep tendon reflexes on left side, weakness in left quadriceps and posterior tibialis, and decreased sensation to light touch over left L5 dermatome. She is again recommended to undergo 9 sessions of physical therapy and continued on current medication program and will be referred for EMG/NCV of lower extremities.

The initial review was performed on 06/21/12. It is noted peer to peer was performed with Dr. who reported the claimant is diagnosed with lumbar sprain/strain, lumbar radiculitis, and contusion to coccyx. He reported the claimant had a few sessions of therapy previously but stopped due to pain. The evaluator recommends an adverse determination. He notes that a soft tissue injury should have resolved by now with the simple passage of time. He notes that there is no evidence on advanced imaging of any injury related pathology that would explain the claimant's presentation. He further notes it is unclear why monitored therapy would be considered over four months out from the alleged injury when a prior therapy trial appears to have been unsuccessful.

The appeal request was reviewed on 07/03/12. The reviewer notes that the issues brought up in the initial level review were not addressed in this request for reconsideration. It is noted that there was no medical rationale or explanation provided for what identifiable lumbar pathology of occupational etiology the requested supervised rehab is meant to address almost five months removed from the occupational injury claim date. The reviewer notes that any soft tissue sprain strain would have resolved months ago. A peer to peer was conducted with Dr. on 07/03/12. The reviewer notes that no additional medical information was provided and therefore the recommendation remains adverse.

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

The request for physical therapy to the lumbar spine times nine visits; neuromuscular reeducation lumbar spine times nine visits; massage therapy lumbar spine times nine visits is not supported as medically necessary and the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant sustained a slip and fall which resulted in a contusion and a strain of the lumbar spine. Imaging studies indicate the presence of degenerative disease in particular at the L5-S1 level. The claimant has undergone a trial of physical therapy with no improvement. Therapy was subsequently discontinued due to increasing pain. The data provided by Dr. is very limited and his clinic notes are brief. These notes do not provide any substantive data which would suggest that the claimant would benefit from additional physical therapy. It is further noted that components of the request are passive in nature and would not be supported by the Official Disability Guidelines five months post date of injury. Further, the clinic note suggests that the claimant's condition is worsening rather than improving and therefore, noting the previous failure, it is unlikely that additional therapy would result in any substantive improvement. Therefore, based on the information provided, the request does not meet Official Disability

Guidelines and therefore remains non-certified.

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)