

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 10, 2012.

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Physical Therapy for the Lumbar Spine 3X week X 2 weeks (97112, 97535, 97110, 97530)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of 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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
847.2, 847.0	97112		Prosp	6					Upheld
847.2, 847.0	97535		Prosp	6					Upheld
847.2, 847.0	97110		Prosp	6					Upheld
847.2, 847.0	97530		Prosp	6					Upheld

TDI-HWCN-Request for an IRO- 18 pages

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a copy of the initial clinical evaluation.. Dr.noted a presenting complaint of right sided neck pain and right low back pain. A decreased range of motion was reported in each region of the spine. The record reflects that no plain films were obtained. The assessment was a sprain of the right neck and left lumbar regions of the spine.

This was treated with medications and a course of physical therapy. The follow-up evaluation was completed noting that the cervical spine pain was better and that the lumbar spine symptoms remained essentially the same. The physical examination noted muscle spasm in the cervical spine and no obvious deformities in the lumbar spine. Straight leg raising was reported as negative bilaterally. The clinical assessment was unchanged and physical therapy was continued and augmented with the medication Robaxin.

Multiple additional follow-up evaluations are noted. Each time it was reported that there was no significant improvement noted for the lumbar spine complaints. The physical examination was unchanged. The diagnosis remained the same. A total of fourteen physical therapy visits had been accomplished. It was noted that a request for an additional six visits was not certified.

Dr. completed a follow-up evaluation. The lumbar spine physical examination noted a full range of motion, no obvious deformities, a slight decrease in range of motion to all planes, and some ongoing muscle spasm in the paraspinal musculature.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines, low back chapter, updated November 2012 allow throughout the ten sessions of physical therapy for a myofascial low back strain. Clearly that parameter has been exceeded. Furthermore, as noted on the physical examination is been no significant improvement to the physical findings reported. There is ongoing muscle spasm and ongoing complaints of pain with no amelioration symptomology. Therefore, the efficacy and utility of additional physical therapy is not established and as such a repeat course of physical therapy (sessions) is not endorsed.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

