



Notice of Independent Review Decision - WC

IRO REVIEWER REPORT – WC

DATE OF REVIEW: 12/03/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3xWKx6-8Wks Cervical/Lumbar/Bilateral Knees 97110, 97112, 97140

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

Board Certified in Physical Medicine & 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 or not medical necessity exists for each of the health care services in dispute.

Physical Therapy 3xWKx6-8Wks Cervical/Lumbar/Bilateral Knees 97110, 97112, 97140 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Referral Form, 09/20/11, 02/15/12
- Spine Evaluation, 03/02/12
- Physical Therapy Sessions, 03/09/12, 03/14/12, 03/19/12, 03/21/12, 03/24/12, 03/30/12, 04/02/12, 04/04/12, 04/10/12, 04/12/12, 04/19/12, 04/26/12,
- Patient Progress Report, 03/30/12, 04/19/12, 04/26/12, 05/10/12
- Referral, 05/12/12, 10/17/12
- Referral, 06/14/12
- Initial Evaluation, 08/31/12
- Denial Letter, 09/07/12, 11/01/12

- Rationale for Request for Continued Physical Therapy, 11/05/12

PATIENT CLINICAL HISTORY [SUMMARY]:

Records available for review indicate that on the date of injury, xx/xx/xx, the patient slipped and fell on the gluteal region. The submitted clinical documentation available for review indicates that the patient received at least eleven sessions of physical therapy at from 03/02/12 until 04/26/12. The records available for review indicate that physical therapy was provided as it related to symptoms referable to the thoracic spine region as well as the right shoulder region and right elbow region. The records available for review indicate that the patient was also with pain symptoms referable to the low back region and bilateral knee region. The records available for review do not document that surgical intervention was ever performed to any of the affected body regions.

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

As stated above, the records available for review indicate that on the date of injury, the patient sustained a fall. The submitted records available for review indicate that the patient was authorized for twelve sessions of physical therapy to the lumbar spine from 07/12/11 to 08/16/11 as well as twelve sessions of physical therapy to the lumbar spine from 08/09/11 to 09/30/11. The records available for review also indicate that from 12/12/11 to 01/27/12, the patient was authorized for six sessions of physical therapy to the cervical spine, thoracic spine, right shoulder, and the bilateral knees. It is documented that the patient was authorized for ten sessions of physical therapy to the right shoulder from 01/30/12 to 03/30/12, twelve sessions of physical therapy to the thoracic spine and lumbar spine from 03/08/12 to 05/31/12, and ten sessions of physical therapy to the thoracic spine, cervical spine, and right shoulder from 04/02/12 to 05/31/12. Additionally, it is documented that the patient was authorized for two sessions of physical therapy to the right shoulder from 05/30/12 to 06/29/12. There is no documentation to indicate that the patient ever received a surgical procedure to an affected physical structure of the body with respect to the work injury of 02/08/11.

Hence, based on the medical documentation currently available for review, Official Disability Guidelines would not support a medical necessity for ongoing medical treatment in the form of supervised physical therapy services. The above-noted reference would support an expectation that an individual should be capable of a proper non-supervised rehabilitation regimen for the described medical situation when an individual is this far removed from the onset of symptoms and when previous treatment has included access to an extensive amount of supervised physical therapy services. As such, in this particular case per criteria set forth by the Official Disability Guidelines, medical necessity for this specific request is not established.

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

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**