

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 10 visits over 8 week period

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG

10/31/11, 12/09/11

Physical therapy orders dated 09/28/11

Patient evaluation dated 10/18/11, 10/25/11

Script image dated 11/29/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. He was setting down a 150 lb water pump at work when he felt a sharp pain in the lower back. The earliest clinical record submitted for review is a patient evaluation dated 10/18/11. The patient presents with a primary complaint of low back pain. MRI reportedly shows a bulged disc at L4-5, per patient report. The patient received a steroid shot shortly after which decreased pain. On physical examination left lower extremity strength is decreased. The patient reports radicular paresthesias on left lower extremity from posterolateral thigh to medial calf. Diagnosis is lumbar disc displacement, lumbago and muscle weakness-general. The request for PT was denied per Official Disability Guidelines, the recommended amount of physical therapy for this patient's diagnosis is 10 sessions over 8 weeks. The request, as stated, potentially far exceeds that recommendation. On 12/09/11 request was denied again this time noting that the records available for review do not document the presence of a focal neurological deficit on physical examination. Official MRI report is not available for review. Specifics are not provided with respect to amount of therapy provided previously.

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

There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. It is unclear if the patient has undergone previous

physical therapy. If not, it is unclear why the initial physical therapy request was submitted over 5 months post injury. The patient reportedly underwent an MRI of the lumbar spine; however, this report is not submitted for review. The reviewer finds no medical necessity for Physical Therapy 10 visits over 8-week period.

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)