

SENT VIA EMAIL OR FAX ON
Jan/03/2012

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/03/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy (PT) 2 X 4 not over an hour per session total

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

Orthopedic Surgery

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

OD Guidelines

Cover sheet and working documents

Utilization review determination dated 10/24/11, 11/16/11

Appeal letter dated 11/09/11

Office visit note dated 09/29/11, 09/28/11, 09/26/11, 09/23/11, 09/22/11, 09/30/11, 10/13/11

MRI lumbar spine dated 10/14/11

Peer review dated 10/07/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date she was lifting a patient and reported pain in the buttocks and low back. The patient has completed 9 sessions of physical therapy to date for diagnoses of thoracic or lumbosacral neuritis or radiculitis, unspecified; displacement of lumbar intervertebral disc without myelopathy; and disorders of sacrum. Peer review dated 10/07/11 indicates that the compensable injury appears to be a lumbar/SI joint strain. Physical examination on 10/13/11 notes straight leg raising is negative.

Fabere is negative. Piriformis stretch is positive. Manual motor testing is rated as 5/5 in the bilateral legs. Sensory exam revealed hyperalgesia on S1 dermatome distribution. Gait is normal. MRI of the lumbar spine dated 10/14/11 revealed mild multilevel spondylosis and disc disease; no significant narrowing of the spinal canal; mild narrowing of the neural foramina at L4-5 and multilevel annular fissuring may contribute to back pain.

Initial request for physical therapy 2 x 4 was non-certified on 10/24/11 noting that the patient is a physical therapist by trade and should be well versed with an independent HEP. Lumbar MRI is negative for occupational pathology. The denial was upheld on appeal dated 11/16/11 noting that the patient has received a standard protocol of physical therapy for treatment of low back pain. In the absence of additional information, adverse determination is recommended as medical necessity for physical therapy in excess of that recommended in the ODG has not been established.

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

Based on the clinical information provided, the request for physical therapy (PT) 2 x 4 not over a hour per session total is not recommended as medically necessary, and the two previous denials should be upheld. Per peer review dated 10/07/11, the compensable injury is a lumbar/SI joint strain. The patient has completed 9 sessions of physical therapy to date. The Official Disability Guidelines support up to 10 visits for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The submitted records indicate that the patient is a physical therapist, and she should be well-versed in a structured home exercise program. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program as recommended by the guidelines.

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)