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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/31/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3 X 2 for cervical area

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

PM&R and Pain 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

Physical therapy notes dated 08/03/10 – 08/13/10

Clinical interview dated 05/29/12

Psychological evaluation dated 05/29/12

Request for individual therapy dated 06/08/12

Psychological interview performed in 08/12

Clinical note by Dr. dated 07/30/10

Clinical notes by Dr. dated 08/06/10 and 08/13/10

Clinical note by Dr. dated 09/13/10

MMI evaluation by Dr. dated 01/14/11

Clinical note by Dr. dated 01/27/11 and 04/25/12

Clinical evaluation by Dr. dated 07/10/12

Clinical evaluation by DC dated 07/10/12

Clinical notes by DC dated 09/26/12 and 10/04/12

Prior reviews dated 10/02/12 and 10/10/12
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury when 70 lbs. struck the patient on top of the head. The patient was initially treated with physical therapy and medications and the patient was placed at MMI in 01/11 by Dr. The patient was seen by Dr. on 04/25/12 with continuing complaints of pain in the upper neck. Physical examination revealed limited range of motion in the cervical spine with tenderness over the facets. The patient was assessed with a cervical strain and was referred for physical therapy. The patient was recommended for a chronic pain management program in 05/12; however, there is no indication that this was approved. The patient was evaluated by Dr. in 07/12 who recommended a detox program coupled with a pain management program, as well as possible medial branch blocks and radiofrequency ablation. The patient was seen by DC on 07/10/12 for complaints of neck pain. Physical examination revealed tenderness to palpation with hypertonicity of the cervical paravertebral musculature. Loss of endpoints of range of motion in the cervical spine was noted. Mild weakness in the left deltoid of the biceps muscle groups were noted as well as weakness in grip strength testing to the left. The patient was recommended for an outpatient therapy program to improve pain and range of motion of the cervical spine. Follow-up with DC on 09/26/12 indicated that the patient continued to have neck pain radiating to the shoulders bilaterally that was interfering with the activities of daily living. Physical examination revealed decreased range of motion in the cervical spine with tenderness in the paraspinal musculature. Dermatomal numbness in the left C5-6 nerve root distribution was noted, and there was mild weakness in the left wrist extensors biceps and on grip strength testing. The patient indicated that she had had no improvements with a home exercise program and the patient was recommended for formal physical therapy to improve range of motion and address cervical tenderness. Follow-up on 10/04/12 with DC indicated that the patient continued to have loss of range of motion in the cervical spine with paravertebral tenderness to palpation. DC suggested that further physical therapy would address the patient's symptoms as prior physical therapy had allowed her to return to work.

The request for cervical physical therapy 3 x 2 was denied by utilization review on 10/02/12 as there was no data to suggest that the claimant would have potential benefit from additional therapy.

The request was again denied by utilization review on 10/10/12 as there were no specified dates of physical therapy in the records and there was no way to discern the patient's prior improvement with physical therapy.

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

Based on the clinical documentation provided for review, the requested physical therapy for the cervical spine for 6 sessions would be supported as medically necessary. Per the clinical documentation provided, the patient underwent a prior physical therapy program in 2010 which resulted in improvement of the patient's symptoms. The patient was evaluated by DC and was found to have a persistent loss of range of motion and paravertebral spasms that did not improve with a home exercise program. DC recommended a formal physical therapy plan to address the patient's range of motion and paravertebral tenderness in an attempt to return the patient to work. As the patient's exam findings were consistent with the claimant's complaints, a trial of 6 physical therapy sessions would be supported by current evidence based guidelines due to the significant re-exacerbation of the patient's symptoms. As the patient has had prior response to physical therapy in the past, an additional trial of 6 sessions of physical therapy would be appropriate and medically necessary. As such, the prior denials are overturned.

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)