

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/18/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient physical therapy four (4) visits over two (2) weeks to the cervical and lumbar spines consisting of therapeutic exercises, therapeutic activities and manual therapy, not to exceed four (4) units per session

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

M.D., Board Certified Family 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. The reviewer finds medical necessity does not exist for Outpatient physical therapy four (4) visits over two (2) weeks to the cervical and lumbar spines consisting of therapeutic exercises, therapeutic activities and manual therapy, not to exceed four (4) units per session.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Texas Worker's Compensation Work Status Reports various dates
Letter of appeal Patient, MPH (undated)
ER records
Encounter notes
Physical therapy initial evaluation and progress notes
Utilization review determination dated 07/06/12
Consultation referral request dated 07/23/12
Utilization review determination dated 07/31/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured in motor vehicle accident. She was transported to emergency department by EMS where she was examined and given Vicodin upon release. Physical therapy initial evaluation indicates the claimant has moderately improved since onset. It was noted the claimant has been able to resume running and health club exercises. Assessment was persistent thoracic and paracervical pain. Physical examination revealed muscle guarding bilateral upper and middle trapezius, and limited mid thoracic segmental mobility. The claimant completed 6 visits of physical therapy as of 06/19/12. The claimant was provided with home exercise program. Office visit note dated 07/02/12 indicated

pertinent findings of no overt C-spine tenderness to palpation, but does have decreased range of motion with trapezial and paraspinous spasm. There was mild upper T-spine tenderness to palpation, right rhomboid tenderness to palpation, and soft tissues. There is no overt L-spine tenderness to palpation, mild tightness to paraspinous muscles. Straight leg raise was negative. Deep tendon reflexes were 2+. Strength was 5/5. C-spine x-ray was negative for fracture or subluxation.

A request for outpatient physical therapy 4 visits over 2 weeks to cervical and lumbar spine consisting of therapeutic exercises, therapeutic activities and manual therapy not to exceed 4 units per sessions was non-certified per utilization review dated 07/06/12. The reviewer noted the claimant is on no medications.

On examination from last office visit there was decreased range of motion in cervical spine in extension and rotation. There was tenderness to palpation and tightness to paraspinous muscles. Back has full range of motion with negative straight leg raise and strength 5/5. No formal range of motion, MMT, or VAS was seen. The reviewer determined the material provided does not establish necessity for further formal physical therapy. A reconsideration request for additional outpatient physical therapy was denied on 07/31/12 noting the claimant has attended 6 sessions of physical therapy and additional 4 sessions of physical therapy to cervical and lumbar spine were non-authorized on 07/05/12. An undated appeal letter from the claimant noted she had minimal improvement and stopped her medications, as they were not reducing her pain. No additional medical documentation presented to determine medical necessity.

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

The claimant sustained injuries secondary to motor vehicle accident. X-rays were negative for any significant pathology. Diagnosis is neck strain and back strain. The claimant has completed 6 visits of therapy to date. A physical therapy evaluation reported the claimant has been able to resume running and health club exercises. She has been provided home exercise program. The request as submitted for review is insufficient to establish medical necessity. There is no evidence of functional deficits with most recent examination reporting 5/5 strength, negative straight leg raise, and 2+ deep tendon reflexes. As such, the reviewer finds medical necessity does not exist for Outpatient physical therapy four (4) visits over two (2) weeks to the cervical and lumbar spines consisting of therapeutic exercises, therapeutic activities and manual therapy, not to exceed four (4) units per session.

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)