US Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/17/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
eight sessions of physical therapy for the lumbar spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon (Joint)

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[ ] Upheld (Agree)
[X] 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 <u>each</u> health care service in dispute. The reviewer finds medical necessity is established for eight sessions of physical therapy for the lumbar spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy notes dated 04/24/12-07/25/12
Clinical notes dated 04/19/10-07/19/12
Prior reviews dated 06/07/12-08/23/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female who sustained an injury on xx/xx/xx when she fell, injuring her lower back. The patient initiated physical therapy on 04/24/12 and continued physical therapy through 07/25/12. Nine sessions of physical therapy were documented to date including the most recent evaluation. Clinical evaluation on 07/19/12 stated that the patient was improving but remained symptomatic with pain 6/10 on the VAS scale. The patient did report weakness in the left lower extremity. Medications at this visit did include Hydrocodone and Ibuprofen. Physical examination revealed loss of range of motion on forward flexion and extension. The patient demonstrated a normal gait and could perform heel and toe walking. No focal or neurologic deficits were present and there was tenderness to palpation over the left hip. Physical therapy evaluation dated 07/25/12 reported loss of range of motion in the lumbar spine with decreased core strength. The request for 8 sessions of physical therapy was denied by Utilization Review on 07/30/12. As clinical notes indicated, the patient was recommended for trigger point injections and did not improve with physical therapy. The request was again denied by Utilization Review on 08/23/12 due to essentially a normal physical exam by a physical therapist.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The records indicate that this patient initially completed eight documented sessions of

physical therapy through May of 2012 with some benefit. The patient was seen in July 2012 with complaints of worsening low back pain and left lower extremity weakness. The physical therapy evaluation on 07/25/12 did identify loss of range of motion in the lumbar spine on forward flexion and extension. The patient did have decreased core strength and there was palpable tenderness in the musculature of the lumbar spine, left worse than right. As the patient continued to demonstrate functional limitations in the lumbar spine with decreased core strength, this would meet guideline recommendations regarding exceptional factors to support additional physical therapy.

Given the patient's exam findings, 8 sessions of physical therapy would be reasonable and necessary to address these functional limitations and would be supported by guidelines. The clinical documentation does address concerns in prior reviews regarding normal findings. The physical therapy evaluation clearly identified focal deficits to include loss of range of motion and core weakness. As such, the reviewer finds medical necessity is established for eight sessions of physical therapy for the lumbar spine.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)