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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: physical therapy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Physical Medicine and Rehabilitation 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. It is the opinion of the reviewer that the request for physical therapy is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 08/06/13, 08/30/13
Letter dated 10/25/13
Handwritten initial evaluation dated 07/30/13
Email (undated)
Patient appointment list dated 08/14/13
Initial evaluation dated 05/10/13
Discharge summary dated 06/25/13
New patient evaluation dated 06/06/13
Follow up note dated 06/20/13, 07/15/13, 07/22/13, 09/09/13
MRI lumbar spine dated 05/23/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date the patient reported low back pain radiating down the left hip. Initial evaluation dated 05/10/13 indicates that diagnosis is lumbago. MRI of the lumbar spine dated 05/23/13 revealed shallow left paramedian disc protrusion at L5-S1 with minimal contact on the crossing left S1 nerve root; shallow central disc protrusion at L4-5 without nerve root impingement or spinal stenosis. Per discharge summary dated 06/25/13, the patient completed 6 physical therapy visits. Follow up note dated 07/15/13 indicates that the patient has had physical therapy, nonsteroidal anti-inflammatories and oral steroids all without any significant relief of symptoms. Follow up note dated 09/09/13 indicates that the patient complains of low back and left buttock pain. On physical examination there is tenderness to palpation at L5-S1 and right buttock. Flexion is limited with increased right buttock and proximal posterior thigh pain on the right side. Extension increased low back symptoms. Straight leg raising on the right at 50 degrees reproduced his right buttock pain and low back pain. Straight leg raising is negative on the left. Reflexes are 2+ and

symmetrical in lower extremities. Strength is rated as 5/5 in the lower extremities.

Initial request for physical therapy was non-certified on 08/06/13 noting that there are limited clinical findings as the notes are difficult to interpret. The patient had 8 PT visits authorized per the referral with no indication how many were completed or what the results were. The patient's diagnosis is lumbar strain which supports up to 10 PT sessions per ODG, but without further clarification on his limitations and progress thus far, further PT is not supported. The denial was upheld on appeal dated 08/30/13 noting that as per ODG physical therapy guidelines, 10 visits over 5 weeks are recommended for sprains and strains of the back. This claimant suffered a sprain of the back about 4 months ago.

He has been treated with medication and 8 PT sessions but continued to have subjective complaints without significant clinical findings. Generally, PT is considered beneficial in the early phase of the sprains and strains. If a patient does not show significant improvement in this phase it is less likely to be beneficial in the chronic phase.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained a low back injury on xx/xx/xx and has completed 8 physical therapy visits to date. The Official Disability Guidelines support up to 10 sessions of physical therapy 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. Per note dated 07/15/13, the patient has completed physical therapy without any significant relief of symptoms. Therefore, efficacy of treatment is not established. 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 such, it is the opinion of the reviewer that the request for physical therapy is not recommended as medically necessary.

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)