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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: PT 3 x Wk x 6 Wks Lumbar
97110 97112 97035 97124 97140 97018 97010 97012

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified Physical Medicine 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 PT 3 x Wk x 6 Wks Lumbar 97110 97112 97035 97124 97140 97018 97010 97012 is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 12/21/12, 11/28/12
Office visit note dated 09/04/12, 10/04/12, 11/29/12, 11/20/12
Designated doctor evaluation dated 07/20/12
Daily therapy treatment note dated 02/23/12, 02/21/12
Plan of care dated 08/21/12
Initial evaluation dated 08/21/12
Physical therapy exercise activity flow chart dated 02/14/12

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient reports he was working and was leaning forward, twisting and pushing while working when he felt a pop in the back. Designated doctor evaluation dated 07/20/12 indicates that the patient was diagnosed with a lumbosacral spine strain/sprain. He was treated with NSAIDs and physical therapy for two weeks and placed on restricted work. He improved and on 02/27/12 he was advised to return to full work with no restrictions. On 04/14/12 he returned because of more significant pain in the lumbosacral spine. He stopped working on 04/16/12 and has not returned to work since then. Diagnoses are listed as lumbar facet joint syndrome; narrowing of the intervertebral foramen with impingement of the right L5 root and radiculopathy; grade I spondylolisthesis and spondylolysis at L5; and 4 mm L5-S1 disc protrusion. The patient I note at MMI and needs specific treatment for the facet joint syndrome and the impingement of the right L5 root, for which he has had no treatment at all. Anticipated MMI date is 11/15/12. The most recent office visit note dated 11/29/12

indicates that back pain is stable and physical therapy is pending. On physical examination lumbar spine shows L5-S1 tenderness and muscle spasm bilaterally.

Initial request for PT 3 x wk x 6 wks with associated modalities was non-certified on 11/28/12 noting that no medical reports from the requesting physician identifying the patient's clinical condition (including subjective/objective findings) have been made available for review. Per 11/20/12 PT evaluation, the patient presents with low back pain with radicular symptoms down the right lower extremity, pain constant and rated 2-7/10; physical examination revealed 50% limitation in lumbar flexion and rotation to the right, 75% limitation in lumbar rotation to the left, SIJ pain, decreased muscle strength, severe loss of core and hip strength and moderate to severe loss of trunk range of motion.

Conservative treatment has included activity modification and PT x 14 visits (as per nurse's summary) which exceed the recommendation of the PT guidelines. In addition, there is no documentation of objective improvement with previous treatment and a statement identifying why an independent home exercise program would be insufficient to address any remaining functional deficits. The denial was upheld on appeal dated 12/21/12 noting that the medical report dated 11/29/12 states that the patient complains of back pain. Physical examination of the lumbar spine showed spasm and tenderness. The nurse's clinical summary indicates that the patient has attended 14 Physical Therapy visits to date. The records provided for review only showed six documented visits from 2/10/12 to 2/23/12, with improvement. Details of the other eight visits are unknown. In addition, the medical note dated 7/20/12 states that the patient has not had any significant treatment for Physical Therapy since February 2012. It is unclear at this time whether the patient had any therapy beyond 7/20/12. In addition, the patient's compliance with an active Home Exercise Program with past treatments is not noted in the records reviewed. The requested number of visits on top of the completed sessions is also in excess of guideline recommendations. There were no exceptional factors mentioned to substantiate this. With these reasons, the medical necessity of the requested service remains to be not established and the previous non-certifications is upheld. The reviewing physician discussed the case. He states he has been following the patient since his initial injury and that he had some transient radicular findings, which have since resolved. His most recent exam shows only some lumbar spasm. The patient did not attend his "full course" of PT earlier in the year, for unclear reasons. Further PT was not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries to the lumbar spine on xx/xx/xx and has completed 14 sessions of physical therapy 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. The patient's objective, functional response to prior therapy is not documented. The patient's compliance with an active home exercise program is not documented. Additionally, the Official Disability Guidelines note that no more than 3-4 modalities should be utilized per session, and passive modalities such as 97035, 97124, 97018, and 97010 are generally not supported. 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 PT 3 x Wk x 6 Wks Lumbar 97110 97112 97035 97124 97140 97018 97010 97012 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)