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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: June 11, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy for Neck, Shoulders and Arms.

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

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)

I have determined that the requested physical therapy for neck, shoulders and arms is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 5/13/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 5/21/13.
3. Notice of Assignment of Independent Review Organization dated 5/22/13.
4. Denial documentation dated 5/7/13 and 5/20/13.
5. Clinic notes from MD dated 3/26/13 and 4/29/13.
6. Initial Physical Therapy Evaluation from MD dated 2/15/13.
7. Prescription for physical therapy dated 5/2/13 from MD.

8. Prospective Review (M2) Response dated 5/23/13.
9. Pre-Authorization/Drug Voluntary Certification Request undated.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work related injury to his back and head on after falling off a truck. The clinical note dated 2/15/13 reported a physical therapy evaluation of the patient. On the same date the provider documented the patient had previously received 12 physical therapy interventions for his cervical spine and bilateral upper extremity pain complaints. The clinical note dated 4/29/13 reported the patient was seen for follow-up. On the same date, the provider documented that the patient continued to present with post concussive syndrome, neck strain, and bruxism. The provider noted the patient recently had undergone an MRI of the cervical spine which revealed no abnormalities. The provider reported upon physical exam of the patient, strength of the left grip was weakened at 3/5, and left upper extremity and left lower extremity muscle strength was 4/5. The provider documented the patient's right upper extremity was 4/5 muscle strength and the right lower extremity was 5/5. The provider documented the patient's reflexes were delayed, hyporeflexive, and 1+ bilaterally. There was significant decreased range of motion of the cervical spine in all planes.

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

In this patient's case, the Official Disability Guidelines (ODG) do not support the requested physical therapy. The clinical notes evidence the patient had utilized 12 previous sessions of physical therapy, however, another peer-review documented 20 sessions. The provider documented the patient has had a change of condition, presenting with significant decrease in motor strength to the bilateral upper and lower extremities. However, there were only two clinical notes submitted for review of the patient and there was no change in the patient's status or functionality. The clinical notes submitted for review do not support significant evidence that the patient is presenting with a decline in his functional status indicative of continued supervised therapeutic interventions. As such, the requested physical therapy for the neck, shoulders and arms is not considered medically necessary.

In conclusion, I have determined the requested physical therapy for the neck, shoulders and arms is not medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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 JUDGMENT, 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)