



Notice of Independent Review Decision - WC

DATE OF REVIEW:

07/10/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy (97112, 97110, 97140) 3 x 4 Weeks

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

Board Certified in Physical Medicine & 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Physical Therapy (97112, 97110, 97140) 3 x 4 Weeks – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Initial Physical Examination, Balance, 03/19/13
- Medical Initial Evaluation, 03/22/13
- Functional Capacity Evaluation (FCE), 03/22/13
- Appeal Letter for Physical Therapy, 04/01/13, 05/20/13
- Cervical Spine Series, 04/09/13
- Lumbar Spine Series, 04/09/13
- Lumbar Spine MRI, 04/09/13
- Evaluation, 04/15/13

- Denial Letters, 05/13/13, 06/11/13
- Physical Examination, 06/06/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The date of injury is listed as xx/xx/xx. On the date of injury, the patient was leaning over to pick up a chair when the patient felt a pop in the low back region and developed symptoms of stiffness in his cervical region.

The patient received an evaluation on 03/19/13. On this date, the patient was diagnosed with a cervical strain and a lumbar strain. It was recommended that the patient receive access to treatment in the form of physical therapy services.

A Functional Capacity Evaluation (FCE) was accomplished on 03/22/13. The evaluation revealed that the patient was capable of sedentary work activities.

dictated a letter on 04/01/13 whereby this physician felt that the patient was in need of ongoing treatment in the form of physical therapy services.

Cervical spine x-rays were accomplished on 04/09/13. This radiographic testing revealed no findings worrisome for an osseous abnormality.

Lumbar spine x-rays were accomplished on 04/19/13. This study revealed no findings worrisome for an acute pathological process. There was evidence for spondylosis at the L5-S1 level.

A lumbar MRI was accomplished on 04/09/13. This study revealed findings consistent with the presence of a 5 mm synovial cyst that projected inferiorly from the right L4-L5 facet joint. There was no evidence of any central canal stenosis or foraminal stenosis. There was evidence for small disc protrusions at the L4-L5 and L5-S1 disc levels.

The patient was evaluated on 04/15/13. On this date, it was documented that previous did include treatment in the form of physical therapy services, as well as prescription medication management. Objectively, there was documentation of good strength in the lower extremities and symmetrical reflexes in the lower extremities. It was recommended that the patient receive access to treatment in the form of a lumbar epidural steroid injection (ESI).

dictated a letter on 05/20/13 at which time this physician felt that the patient was in need of additional treatment in the form of physical therapy services.

The patient was evaluated on 06/06/13. On this date, the patient was with symptoms of cervical pain and low back pain described as 5/10. It was recommended that consideration be given for testing in the form of an electrodiagnostic assessment.

A medical document dated 06/11/13 indicated that the patient had been authorized for at least ten sessions of physical therapy services previously.

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

Based on the records available for review, there would not appear to be a medical necessity for treatment in the form of physical therapy services as it relates directly to the work injury of xx/xx/xx. The records available for review would support that the primary medical condition referable to the work injury of xx/xx/xx is a strain of the affected body regions. The records available for review indicate that there were symptoms of pain referable to the cervical region and the low back region. Per the criteria set forth by the Official Disability Guidelines, the Neck and Upper Back Chapter, as well as the Low Back Chapter, it would be realistic to expect that an individual should be capable in a proper non-supervised rehabilitation regimen for the described medical situation when an individual has received access to the amount of supervised rehabilitation services previously authorized. The records available for review do not document the presence of any neurological deficits on physical examination. The records available for review indicate that objective diagnostic testing accomplished after the date of injury does not reveal any findings worrisome for an acute pathological process. As such, in this particular case, per the criteria set forth by the above noted reference, there would not be a medical necessity for current medical treatment in the form of physical therapy services.

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

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**