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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Feb/23/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3 x Wk x 4 Wks. Lumbar

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

PM&R 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 02/01/13, 01/25/13

Referral form dated 01/22/13, 01/04/13

Plan of care dated 12/27/12

Note dated 11/05/12

Progress note dated 10/09/12, 08/27/12, 12/18/12, 08/13/12, 07/09/12

Operative report dated 09/19/12, 08/15/12

MRI lumbar spine dated 04/13/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was trying to lift a heavy box. MRI of the lumbar spine dated 04/13/12 revealed posterior bulging disc at L4-5. The patient underwent lumbar transforaminal epidural steroid injection on the left at L4-5 and L5-S1 on 08/15/12. Follow up note dated 08/27/12 notes 50% pain reduction for his lower back and 80% for legs. The patient underwent a second epidural steroid injection on 09/19/12 followed by 100% pain reduction for two days with increased activity and an overall reduction of 50%, per note dated 10/09/12. Progress note dated 12/18/12 indicates that on physical examination deep tendon reflexes are 2+ throughout. Sensation is decreased in left

L4-5, L5-S1 dermatomes. Lumbar range of motion is decreased. Straight leg raising is positive on the left at 60 degrees. Plan of care dated 12/27/12 indicates that treatment to date includes decompression surgery, two injections and 4 weeks of PT.

Initial request for physical therapy 3 x wk x 4 wks lumbar was non-certified on 01/25/13 noting that it was noted that he had previous PT; however, the total number of sessions completed as well as objective response to treatment were not documented for review. The denial was upheld on appeal dated 02/01/13 noting that the patient has completed an unknown number of physical therapy visits to date. The patient's objective, functional response to therapy is not documented to establish efficacy of treatment and support additional sessions. The patient's compliance with an active home exercise program is not documented. Current evidence based guidelines note that no more than 3-4 modalities should be utilized per session, and ODG does not support the utilization of modalities 97112, 97113 and 97014.

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

The patient sustained injuries on xx/xx/xx and has completed two epidural steroid injections as well as four weeks of physical therapy, per plan of care dated 12/27/12. The Official Disability Guidelines support up to 10 visits of physical therapy over 8 weeks 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. As noted by the prior reviewer, the patient's compliance with an active home exercise program is not documented. 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 the guidelines recommend. As such, it is the opinion of the reviewer that the request for physical therapy 3 x wk x 4 wks lumbar 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)