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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/05/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: physical therapy (3wk4) or 12 sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified 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 (3wk4) or 12 sessions is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient was on a small step pushing open a steel door when the wind blew the door into his left shoulder and something snapped in his low back. The patient underwent Gill procedure with complete removal of the lamina of L5; L5-S1 left discectomy and PLIF on 03/27/09. IME dated 08/04/10 indicates that the patient does not require formal physical therapy at this time. IME dated 10/13/11 indicates that no further medications or any formal medical treatment is needed. The patient can be on a home exercise program and OTC medication only. Lumbar MRI dated 03/27/13 revealed postoperative changes; small posterior central disc protrusion at L4-5 with minimal thecal sac impingement; left posterolateral disc bulge, mild left neural canal narrowing at L2-3 and right paracentral and posterolateral disc bulge and right neural canal narrowing at L4-5; no evidence of significant spinal or neural canal stenosis.

Follow up note dated 09/06/13 indicates that the patient's pain inexplicably increased dramatically approximately three months ago. Re-examination dated 09/30/13 indicates that diagnosis is spondylolisthesis at the L5-S1 level, postoperative state reduction and fusion with residuals (failed back syndrome, post laminectomy syndrome). Ongoing medical treatment is opined to be reasonable and necessary in pain management due to the compensable injury; however, no further diagnostic studies, injections or chiropractic treatment are recommended. Follow up note dated 12/30/13 indicates that lumbar range of motion is decreased with flexion to 23 degrees, extension 12, right lateral flexion 15 and left lateral flexion 17 degrees. A decrease in deep tendon reflex is noted at the lower extremities

bilaterally at +1/2. Muscle strength in the left lower extremity is rated as 4/5. Straight leg raising, Kemp's test, heel/toe walk and Minor sign are positive. Note dated 01/24/14 indicates that there is decreased sensory on the left. Straight leg raising is positive to 30 degrees bilaterally.

Initial request for physical therapy 3 x a week x 4 weeks was non-certified on 01/20/14 noting that the doctor states the claimant never had any postoperative PT since the surgery was performed and so is now requesting postoperative PT for the claimant. The claimant is almost 5 years post op at this time. The claimant has long exceeded the time frame recommended for post op PT by the evidence based guidelines. The RME state chiropractic care is not necessary to treat this work injury; this is also included within the current request. Passive therapies like ultrasound are not supported for this work injury, yet they are included within the current request. The current request exceeds a trial of care as well as the time frame for post op PT and the allowed and recommended units of PT per session with chiropractic, PT, active PT and passive therapies not supported for this claimant's work injury. Letter of medical necessity dated 01/30/14 indicates that the patient developed a severe sinus infection after the surgery and postoperative physical medicine and rehabilitation was never ordered for the patient. The denial was upheld on appeal dated 02/06/14 noting that has been treating the patient for one year and had no explanation for why he waited an additional year before requesting PT. The claimant is over 4 years status post-surgery and should do just as well with a self-directed home exercise program at this time. There are no red-flags or compelling rationale to substantiate medical necessity of the request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in xx/xxxx and subsequently underwent Gill procedure with complete removal of the lamina of L5; L5-S1 left discectomy and PLIF on 03/27/09. The patient has now been recommended for postoperative physical therapy. The Official Disability Guidelines support up to 34 visits of postoperative physical therapy over 16 weeks for the patient's diagnosis; however, there is no clear rationale provided to support initiation of postoperative physical therapy nearly 5 years post-surgery. There is no clear rationale provided as to why an independent, self-directed home exercise program would be insufficient to address the patient's pain and dysfunction. The request is excessive as the Official Disability Guidelines support an initial trial of 6 visits of physical therapy to establish efficacy of treatment. As such, it is the opinion of the reviewer that the request for physical therapy (3wk4) or 12 sessions 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)