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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/25/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: PT 2 x 4 weeks for the lumbar

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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 PT 2 x 4 weeks for the lumbar 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 mechanism of injury is described as a fall. Progress note dated 01/09/14 indicates that the patient has completed 20 physical therapy visits to date. He has some difficulty with compliance attending therapy due to dependency on outside transportation. He has not made improvement with strength, posture and function, possibly due to disapproval of bilateral lower extremities prescription. Office visit note dated 01/30/14 indicates that the patient complains of neck and low back pain. He rates his low back pain as 6/10 and neck pain as 8/10. He is not currently taking any medications for this pain. On physical examination lumbar range of motion is painful and restriction to 75% of normal flexion and 50% of normal extension. Spinous processes are non-tender. Straight leg raising is normal bilaterally. There is decreased sensation in the bilateral feet in a stocking distribution. Motor exam is non-focal. Deep tendon reflexes are 2+ and symmetric.

Initial request for PT 2 x 4 weeks was non-certified on 01/21/14 noting that the claimant has already received at least twice the maximal amount of PT recommended by national evidence based medical guidelines. The only notes provided document no recent progress with formal PT. This patient should be transitioned to an independent home exercise program for any residual symptoms. The denial was upheld on appeal dated 02/12/14 noting that the patient has completed 20 physical therapy visits for the lumbar spine to date. Current evidence based guidelines support up to 10 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery 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.

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 20 physical therapy visits for the neck and low back to date. The Official Disability Guidelines would support up to 10 visits of physical therapy over 8 weeks for diagnosis of lumbar sprain and strain. The submitted records fail to provide a compelling rationale to support continuing to exceed ODG recommendations versus transitioning the patient to a self-directed home exercise program. As such, it is the opinion of the reviewer that the request for PT 2 x 4 weeks for the 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)