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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/30/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: additional physical therapy 2-3 x 4-6 lumbar spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Orthopedic Surgery

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 additional physical therapy 2-3 x 4-6 lumbar spine is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. Physical therapy initial evaluation dated 07/09/14 indicates diagnosis is degenerative joint disease of the facet joints and lumbar degenerative disc disease. The patient subsequently completed 8 physical therapy visits. Note dated 08/08/14 indicates that the patient reports his symptoms have worsened. He complains of persistent left sided low back pain. Straight leg raising is positive on the left at 35 degrees. Lumbar range of motion is flexion 10, extension 10, and bilateral side bending 5 degrees, all unchanged. Office visit note dated 08/11/14 indicates that he aggravated his back pain at work and it is back to 6-8/10. He is currently working light duty restrictions. Medication is Mobic. On physical examination gait is balanced. Paravertebral muscles are tender on the left. Lumbar range of motion is painful and restricted with extension at 50% of normal, bilateral rotation at 50% of normal and bilateral lateral bending at 50% of normal. Flexion is non-painful. Straight leg raising is positive on the left. Lower extremity strength is symmetrically present in all lower extremity muscle groups. Reflexes are symmetrically present and normal. Light touch is normal for all lumbar dermatomes.

Initial request for additional physical therapy 2-3 x 4-6 lumbar spine was non-certified on 08/14/14 noting that the patient has had 8 visits of physical therapy with improvement. There is reduced motion and tenderness. There is intact strength. The claimant should be able to transition to a home exercise program. The request for 18 additional supervised physical therapy visits exceeds evidence based guidelines. The denial was upheld on appeal dated 08/25/14 noting that the additional therapy would exceed ODG guidelines. While a course of physical therapy would be indicated to address the flare-up, the request could not be modified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained an injury to the low back on xx/xx/xx and has completed 8 physical therapy visits to date. The Official Disability Guidelines support up to 10 sessions of physical therapy 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. 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 such, it is the opinion of the reviewer that the request for additional physical therapy 2-3 x 4-6 lumbar spine 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 KNOWLEDGBASE

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)