

**I-Resolutions Inc.**  
An Independent Review Organization  
3616 Far West Blvd Ste 117-501  
Austin, TX 78731  
Phone: (512) 782-4415  
Fax: (512) 233-5110  
Email: manager@i-resolutions.com

**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE NOTICE SENT TO ALL PARTIES:** Jul/30/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** eight to eighteen sessions of physical therapy for the lumbar spine

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Neurological 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 this reviewer's opinion that the requested eight to eighteen sessions of physical therapy for the lumbar spine would not be medically necessary

**PATIENT CLINICAL HISTORY:** The patient is a female who was injured on xx/xx/xx when a x was pushed into her back. The patient was initially assessed with a low back strain injury. The patient completed a period of physical therapy for 12 sessions. There was a physical therapy assessment dated 06/15/15 which was handwritten noting that the patient's symptoms had decreased with previous physical therapy but were not totally resolved. MRI studies which were not available for review were reported to show evidence of a disc herniation from L3 through L5 with spondylitic changes. The patient disc eye described a mild pain in the right lumbar region radiating to the right upper buttock. The patient described pain while getting out of bed and standing for more than 30 minutes. The clinical assessment noted myofascial tightness in the lower lumbar spine region. Range of motion was restricted on extension and side bending. Flexion was to 70 degrees. The patient was able to heel and toe walk and reflexes were 2+ and symmetric in the lower extremities. There was some weakness present in the abdominals for minus over five. Some weakness was noted on hip flexion bilaterally 4/5 and on adduction 4-4-/5. Straight leg raise signs were negative at 90 degrees. Oswestry disability index score was 26%. The patient was recommended for further physical therapy to increase strength and range of motion and to reduce pain. The requested physical therapy between eight and eighteen sessions for the lumbar spine was denied by utilization review as there was a lack of physical examination findings to include significant deficits in range of motion weakness or pain to exceed to support exceeding guideline recommendations regarding the maximum amount of physical therapy for low back injuries. The request is again denied on 07/01/15 due to lack of clinical documentation regarding exceptional factors to support ongoing physical therapy beyond guideline recommendations.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The clinical documentation submitted for review does note mild loss of range of motion and some mild weakness in the lower extremities following the patient's last period of physical therapy for 12 sessions. None of the patient's prior physical therapy reports were available for review noting the progression of improvement obtained with the previous physical therapy program. The clinical documentation submitted for review did not include any specific clinical assessments from the patient's prescribing physician regarding goals to be completed with additional physical therapy. Per guidelines physical therapy exceeding the maximum recommended under the guideline recommendation should be supported by exceptional factors. In review of the patient's physical therapy assessment findings there was no identification of significant exceptional factors to support further formal physical therapy over any home exercise program. Therefore it is this reviewer's opinion that the requested eight to eighteen sessions of physical therapy for the lumbar spine would not be medically necessary and the prior denials are upheld.

**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)