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Notice of Independent Review Decision

Reviewer's Report

DATE OF REVIEW: July 24, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Twelve (12) sessions of physical therapy (97110).

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

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)

The requested twelve (12) sessions of physical therapy (97110) is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx. The mechanism of injury was not provided. The patient's diagnoses include chronic pain syndrome and lumbosacral radiculitis. A physical therapy evaluation on 6/3/15, documented the patient complained of low back pain that radiated into the right buttock, thigh, calf, and foot. The patient described the pain as sharp, aching with numbness. The patient reported that the pain was increased with sitting, standing, and lying supine. It was noted that the patient was previously treated with physical therapy and a work hardening program. The physical examination revealed decreased sensation to light touch in the right L4 dermatome.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. The denial letter dated 7/2/15 indicates that the patient received 12 sessions of postoperative therapy in April 2015 and there is no documentation regarding attendance or response to that treatment.

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

Per Official Disability Guidelines (ODG), the recommended amount of physical medicine treatment should be an option when there is evidence of a musculoskeletal or neurologic condition that is associated with functional limitations. ODG guidelines recommend 10-12 physical therapy sessions for lumbosacral radiculitis. In this case, the clinical documentation indicated that the patient had completed 12 sessions of physical therapy in April 2015. The physical examination revealed restricted range of motion. There were no exceptional factors to justify additional supervised visits over participation in a home exercise program. Given the above, the requested additional 12 sessions of physical therapy is not medically necessary. In accordance with the above, I have determined that the requested 12 sessions of physical therapy is not medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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 JUDGMENT, 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)