

US Decisions Inc.

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DATE NOTICE SENT TO ALL PARTIES: Jun/04/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 12 sessions (3 times a week for 4 weeks) of physical therapy for lumbar spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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 this reviewer that the request for 12 sessions (3 times a week for 4 weeks) of physical therapy for lumbar spine is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: is a female. On xx/xx/xx, the patient was seen in clinic. It was noted since her last visit her symptoms had not changed. She was being actively treated for lumbago, lumbar radiculopathy, lumbar sprain and sciatica. It was noted the last visit medications, had been prescribed, as well as ordering an epidural steroid injection and recommendation for a home exercise program. There had been improvement with medications and the patient has not had epidural steroid injections. Upon physical examination, paraspinal muscles were non-tender to palpation except for in an L1 to L5 distribution. There was no instability. The patient reported limited range of motion in all planes secondary to pain and strength testing of the paraspinal muscles was within normal limits. There was no muscle atrophy but the patient had a positive bilateral straight leg raise. On 03/09/15, the patient was seen for physical therapy evaluation. Pain was rated at 5/10 at that time. She had no sensory loss but did exhibit a positive straight leg raise on the left. Physical therapy 3 x a week for 4 weeks for therapeutic exercises, modalities, and a McKenzie protocol to include mobilization as indicated and home program instructions were recommended.

On 04/01/15, the patient was seen back in clinic and it was noted her symptoms have improved. It was noted the patient had attended 10 sessions of physical therapy with improvement. On exam the patient had diffused tenderness from L1 to L5 paraspinal muscles, and range of motion was limited secondary to pain. There is no muscle atrophy noted. The patient had a positive left straight leg raise. Strength was assessed at 5/5 in all muscle groups tested, deep tendon reflexes were 2+ bilaterally and the patient had a normal gait.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 03/19/15, an adverse determination letter was submitted for the requested therapeutic exercises, manual therapy techniques, and therapeutic group exercises, for 12 sessions of physical therapy for the back. It was noted at that time the patient has had 12 physical therapy sessions to date and 1 month of a TENS unit

and per guidelines, it was noted the patient should be doing active home exercises. The request was not authorized. On 04/17/15, an adverse determination letter was submitted for the requested therapeutic exercises, manual therapy techniques, and therapeutic group exercise for 12 sessions of physical therapy 3 x a week for 4 weeks to the lumbar spine, and it was noted guidelines recommend 10 visits over 8 weeks for lumbar sprains and strains. It was noted there needed to be a recent exam by the treating doctor to assess current deficits and clinical rationale in correlation to the 12 additional supervised physical therapy visits. It was noted the patient should be able to transition to a home exercise program at that time. The request was non-certified.

The records submitted for this review indicate the patient has had at least 10 sessions of physical therapy to date and while the provider on 04/01/15 notes the patient is improved, and updated physical therapy note has not been provided. For physical therapy to the lumbar spine, guidelines recommend 10 visits over 8 weeks for lumbar sprains and strains, and for lumbago or back ache unspecified, 9 visits over 8 weeks is recommended. The records do not give a rationale for exceeding guideline recommendations at this time. Therefore, it is the opinion of this reviewer that the request for 12 sessions (3 times a week for 4 weeks) of physical therapy for lumbar spine is not 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)