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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: April 16, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy at the frequency of three (3) times per week for four (4) weeks for the lumbar spine.

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 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)

The requested physical therapy at the frequency of three (3) times per week for four (4) weeks for the lumbar spine is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported a work-related injury on xx/xx/xx. The mechanism of injury was due to a fall down stairs. The patient's diagnoses include sacroiliac (SI) pain, lumbar strain, and myofascial pain syndrome. Magnetic resonance imaging (MRI) of the lumbar spine dated 7/31/14 revealed clumping of the lumbosacral nerve roots to the thecal sac below L3 consistent with arachnoiditis and posterior annular disc bulge from L3-4 and L5-S1 without neural encroachment. The patient has been treated with 12 sessions of physical therapy, an SI joint

injection and medications for pain. The records indicate that physical therapy did help but once therapy ended, she regressed. The patient is requesting another 12 sessions of physical therapy. The clinical note dated 1/28/15 indicates subjective complaints of sharp, aching lower back pain. Objective findings indicated range of motion to the lumbar region was normal bilaterally, with lumbar myofascial tenderness noted. There was a positive Faber's test. The record documents the patient utilizes a home exercise program.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. The denial letter dated 3/13/15 indicates that the 12 sessions already completed exceeds the guideline criteria and the patient should be well-educated enough to perform a daily home exercise program for the long term.

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 therapy sessions for lumbar strain is 10 sessions over 8 weeks. According to the clinical notes submitted for review the patient has exceeded the amount of recommended sessions, as she has already completed 12 physical therapy sessions. Additionally, the patient has no significant factors or documentation of any significant changes to her condition that would warrant the need for 12 additional sessions of physical therapy. For the reasons provided, the medical necessity for the requested services has not been established. In accordance with the above, I have determined that the requested physical therapy at the frequency of three (3) times per week for four (4) weeks for the lumbar spine 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)