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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 3/16/18

IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
XX physical therapy sessions, manipulation and acupuncture XX.

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 with Sub-specialty Certification in 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)

I have determined that the requested services, XX physical therapy sessions, manipulation and acupuncture, are not medically necessary for treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XX who was injured on XXXX. The mechanism of injury was detailed as tripping and falling on uneven ground. The pertinent prior treatments included physical therapy and a cortisone injection. The patient was evaluated with magnetic resonance imaging (MRI) of the right hip without contrast on XXXX, and this revealed mild right hip osteoarthritic changes and low-grade chondromalacia. The patient had mild gluteus medius and gluteus minimus tendinosis. The evaluation report of XXXX noted the patient had constant right hip and thigh pain. The patient rated the pain as 4-6/10. The physical examination revealed a positive Hibbs test that produces mild to moderate pain on the right. The patient had moderate tenderness to palpation in the right hip joint. The patient had moderate tenderness and muscle tightness in the iliotibial band, gluteal major and gluteal medial muscles. The diagnosis was strain of muscle, fascia and tendon of right hip, initial encounter. The treatment plan included XX of physical therapy with myofascial release, joint mobilization, neuromuscular active muscle strengthening,

and joint manipulation for reduction of pain to the right hip. The patient was evaluated with MRI of the right hip on XXXX which revealed a partial thickness tearing of the right gluteus medius tendon insertion into the greater trochanter with trochanteric bursitis. The treatment prescription dated XXXX included XX of therapeutic exercise, manipulation and acupuncture. The patient has requested XX physical therapy sessions, manipulation and acupuncture. The Carrier has denied this request and reported that the requested services are not medically necessary per Official Disability Guidelines.

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

The Official Disability Guidelines state that acupuncture is appropriate for the treatment of the hip and pelvis for patients who have osteoarthritis. Manipulation is recommended for 1-5 times per week as indicated by the severity of involvement and the desired effect. The optimum duration is 3-6 treatments, and the maximum duration is 10 treatments. Physical therapy is recommended for sprain and strain of the hip or thigh for 9 visits over 8 weeks and when treatment duration and the number of visits exceed guidelines, exceptional factors should be noted. Acupuncture is not supported per the guideline recommendations, as the patient does not have osteoarthritis. The documentation provided for review indicated the patient has undergone prior physical therapy. However, the quantity of sessions previously attended were not noted. Furthermore, it is unclear whether the patient has previously been treated with manipulation. The patient should be well-versed in a home exercise program. Without documentation of the above information, the prior determination has been upheld.

Therefore, I have determined the requested services, XX physical therapy sessions, manipulation and acupuncture are 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**

1. Official Disability Guidelines (ODG), Treatment Index, 15th Edition (web), 2017, Hip and Pelvis Chapter, Acupuncture, Manipulation, Physical Medicine Treatment.

☐ **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)**