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IRO REVIEWER REPORT

Date: 1/29/2018 2:46:33 PM CST

IRO CASE #: XXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
12 Physical Therapy for the Lumbar Spine 3 X week X 4 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Physical Medicine and Rehab

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a XX-year-old XXXX with a history of an occupational claim from XXXXX. The mechanism of injury is detailed as XXXXX. Prior relevant treatment includes physical therapy, MRI, activity modification and a work hardening program. On XXXXX the patient was seen complaining of low back pain. The patient reported XXXX had not improved since the previous visit. The patient denied numbness and tingling but reported lower back pain. The patient had finished a work hardening program and was not ready to return to work and the therapist suggested physical therapy program to strengthen the core prior to return to work. On examination, strength was normal and reflexes were symmetrical. There was only subjective dysesthesia. Straight leg raise was negative bilaterally. There was no lower extremity wasting. The patient was diagnosed with lumbar disc disease, postlaminectomy syndrome and chronic pain. The patient was recommended physical therapy program.

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

Although not exclusive by definition, therapeutic exercise is any exercise planned and performed to attain a specific goal. Goals would be to increase strength, endurance, range of motion, and flexibility. Indications must be documented for loss or restriction of joint motion, reduced strength, and functional capacity or mobility concerns. The clinical records must show objective (quantitative if possible) loss of ROM, strength, flexibility or mobility. The medical records to support and justify the use of therapeutic procedures/exercises must include evidence to support medical necessity; a plan of care with specific

and measurable goals and timeframe for initiating, progressing, and discharging the patient from skilled medical services to an independent home program; detailed description of active care services; and evidence to support the need for skilled services by a licensed professional in direct contact with one patient. In this case the documentation provided for review indicates the patient had physical therapy, MRI and completed a work hardening program. The patient reported XXXX did not improve since the previous visit. The patient had finished a work hardening program was not ready to return to work. The therapist suggested a physical therapy program to strengthen the core prior to return to work. On examination strength was normal and reflexes were symmetrical. There was only subjective dysesthesia. Straight leg raise was negative bilaterally. There was no lower extremity wasting. There were no specific indications such as loss of restriction of joint motion, reduced strength or functional mobility concerns. There was no objective/quantitative loss of range of motion, strength, flexibility or mobility. There was no documentation of a barrier to performing a home exercise program. The medical records provided did not support and justify the use of therapeutic procedure/exercises. As such, 12 physical therapy for the lumbar spine 3 x a week ×4 weeks is not medically necessary.

Therefore, the prior determination is upheld.

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

☐ AHRQ- 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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☒ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

1. 2016 NIA Clinical Guidelines for Medical Necessity Review. Physical Medicine pages 614-657. Retrieved from: http://www1.radmd.com/media/377496/_ _2016-master-nia-clinical- guidelines.pdf
2. Akyuz, G., & Kenis, O. (2014). Physical therapy modalities and rehabilitation techniques in the management of neuropathic pain. American journal of physical medicine & rehabilitation, 93(3), 253-259. 3. O'Sullivan, S. B., Schmitz, T. J., & Fulk, G. (2013). Physical rehabilitation. FA Davis.