True Decisions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 4/30/2018 7:58:14 AM CST

True Decisions Inc.

An Independent Review Organization
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IRO REVIEWER REPORT
Date: 4/30/2018 7:58:14 AM CST
IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Physical Therapy 3 X 3

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: General Surgery, Plastic Surgery

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 with a history of an occupational claim from XXXX. XX was injured while XX, when XX felt a pop in the left inguinal area. The diagnosis was listed as inguinal hernia. According to the operative report dated XXXX, the patient underwent hernia repair for the incarcerated left inguinal hernia. XX was evaluated on XXXX, with pain in the lumbar spine, described as aching, numbing, and swelling. Heat was somewhat helpful. On examination, there was moderate restriction to range of motion in the lumbar spine. Straight leg raise is positive on the left. The treatment plan included recommendation for physical therapy. According to available documentation, the request for physical therapy was previously denied, given that guidelines do not support the use of physical therapy following hernia repair.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Regarding the request for physical therapy, the Official Disability Guidelines state that physical therapy is not recommended for hernia as there is no evidence of successful outcomes compared to surgery. Therapy may be recommended for Sportsman's groin. In this case, as previously noted, the patient did report with some restricted range of motion in the low back. XX was noted to have undergone hernia repair on XXXX. However, given that guidelines do not support therapy following hernia repair, there were no exceptional factors noted to support this treatment modality outside of guideline recommendations for treatment.
As such, the prior determination is upheld, and physical therapy 3×3 is not medically necessary.

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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

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Hernia, Physical therapy (PT)