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IRO Certificate #4599

DATE OF REVIEW: 4/13/18

IRO CASE NO. XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Post operative physical therapy; CPT 97530 97110 97140 97010

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Physical Medicine & Rehabilitation

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

Upheld (Agree)

Overturned (Disagree) X

Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
Patient is a XX with injury date XXXX, mechanism of injury described as XX: injury occurred when XX described as severe in nature that worsened with movement and daily activities. Diagnostic imaging revealed fat containing right greater than left inguinal hernias (CT of the abdomen and pelvis). Diagnosis was incarcerated bilateral inguinal hernias requiring surgical intervention.

Patient underwent surgical hernia repair XXXX and despite this, continued to have post operative pain. The last office visit note I have for review is XXXX where the patient was still requiring time off from work due to continued pain related to surgery. Prior to this, per office visit note dated XXXX, XX was still being prescribed XX and XX. Patient remained off work as XX was unable to meet minimum job restrictions, ie, decreased range of motion, pain at incision site, swelling, tenderness, and weakness.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
Opinion: I disagree with the benefit company's decision to deny the requested service.
Rationale: After reviewing all documents presented, including the denials, I disagree with the decision to deny the service. The rationale for the denial is stated as no documentation noting range of motion values on all planes and, additionally, guidelines should not recommend physical therapy for hernia. My opinion, given that the general surgeon who performed the surgery, had stated that the surgery went well and there were no post-operative complications. The patient still has pain and limitations, particularly lifting and working at XX physical demand level. It should be noted that there are different surgical repair techniques for hernia repair, but they all include some degree of cutting into the musculature and fascia in order for the surgeon to access the abdominal wall and repair the hernia. The trauma of the surgery results in scar tissue which ultimately results in dysfunction such as altered motor control patterns, muscular weakness, and decreased mobility of the area as detailed in XX notes where XX states that there is muscular weakness and decreased range of motion. These dysfunctions lead to decreased physical performance and increased risk for additional future injuries. While the surgical intervention went well, it is this dysfunction, particularly the muscular, fascial plane abnormalities after surgery and the scar tissue, that needs to be addressed in the physical therapy and, as such, I am going to recommend and opine that the physical therapy requested should be approved to allow the patient to come off of opioids

and analgesics and return to XX physical demand level to attain the goals that XX is seeking.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

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