MEDRX

3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 3/31/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of Physical Therapy Sessions 3 times a week for 2 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehab

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 reviewer agrees with the previous adverse determination regarding the Physical Therapy Sessions 3 times a week for 2 weeks

PATIENT CLINICAL HISTORY [SUMMARY]:
Worker sustained a fall injury xx/xx/xx. Treatment included medications and physical therapy for back pain, thoracic, cervical strain, neck pain, strain of the thoracic region and trapezius strain. On an outpatient follow-up visit 02/01/2015 noted that the pain level was 6/10, involving the cervical spine, right trapezius, right arm, and thoracic paraspinous muscles. The worker had received 14 sessions of physical therapy. The pain level was reported to be unchanged since the last PT session in December, 2014. The current medications were Mobic and Flexeril. Physical examination revealed tenderness to palpation over paraspinous

cervical muscles, trapezius and paraspinal thoracolumbar muscles right greater than left, with muscle tightness. The patient had an antalgic gait and a rounded back posture. recommended further physical therapy. The patient continued to work with no restrictions.

On the physical therapy reevaluation 02/06/2015 it was noted that the worker had received 15 total therapy visits. The pain level was reported to be unchanged since the last PT session in December, 2014. She could not perform recreational activities independently. Active problems were back pain, thoracic, cervical strain, neck pain, strain of the thoracic region and trapezius strain.

On the February 14 follow-up visit the patient had been doing massages on her own which helped but still had a lot of pain and stiffness. Examination revealed tenderness to palpation over paraspinal cervical muscles bilaterally. There was tenderness to palpation over thoracolumbar paraspinous muscles and over the trapezius. Due to the delayed recovery, recommended continuing therapy and an orthopedic referral. In the meantime the patient would continue the home exercise program and the medications.

On 02/16/2015 the requested physical therapy was nonauthorized. After reconsideration the requested therapy was nonauthorized on 02/26/2015. On 03/05/2016 a request was submitted for review by an Independent Review Organization.

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

Based on the records submitted for review, the requested therapy sessions are not recommended at this time.
The injured worker is more than five months post injury with persistent pain despite therapy, medications (including prescription pain medications) and a home exercise program. The requested further physical therapy sessions exceed the recommendations in the guidelines. According to the reviewed records, the injured worker continues to work full time without restrictions. The worker's ADL status is not itemized in the reviewed records, but according to the physical therapy note of 02/06/2015 she cannot perform recreational activities independently.

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 JUDGEMENT, 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)**