

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Fax: 214-594-8608

Notice of Independent Review Decision

DATE OF REVIEW: APRIL 12, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE Ultrasound 15 minutes; Aqua Therapy; E-Stimulation; Neuromuscular Reeducation; Gait Training 15 min; Manual Therapy techniques 15 minutes; PT Eval; Patient re-eval; Therapeutic Exercises.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board-certified in Internal 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)

Neuromuscular Re-education, gait training, manual therapy techniques, PT eval, and therapeutic exercises are medically necessary.

Ultrasound, Aqua therapy, and E-stimulation are not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

Mr. was injured in a motor vehicle accident in xx/xx. Lumbar MRI showed L4-5 HNP that did not respond to conservative care. In August 2006 he underwent L4-5 microdiscectomy. While participating in a conditioning program, Mr. developed more pain. Lumbar MRI revealed recurrent HNP at L4-5. In August 2007 he underwent L4-5 discectomy and fusion. Post-operative notes indicate functional deficits. Physical therapy was prescribed, but the notes indicate this therapy was not performed.

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

The Reviewer has reviewed the applicable guidelines and the peer-reviewed medical literature concerning PT in the treatment of the fused spine. 12 visits over 4 weeks would be reasonable, provided objective evidence of improvement is documented. This therapy should be active in nature, with a focus on transition to a home-based exercise and flexibility program. However, Ultrasound, aqua therapy, and electrical stimulation are not recommended as medically necessary.

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)**