

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 23, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy, 12 Sessions, 4x/week x 3 weeks

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

MD, Board Certified Orthopedic Surgeon

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Physical Therapy, 12 Sessions, 4x/week x 3 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/5/08, 7/18/08

Chart of Services

Letter to IRO, 8/12/08

MD, 6/3/08

MD, 6/3/08, 5/29/07, 1/16/07

MD, 9/12/07

ODG-TWC-Low Back, Physical Therapy

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker has undergone lumbar spinal surgery. Apparently there is information in the medical records concerning previous physical therapy treatments of 164 sessions as well as pain management and apparently a spinal cord stimulator. There is some notation that the stimulator does not provide significant relief. Request is for 12 additional sessions of physical therapy. Previous reviewers have denied further therapy due to the fact that the medical records do not have an indication of why 164 sessions of therapy, pain management, and a neural stimulator, physical therapy at this point could help.

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

The medical records do not explain the reason for the use of additional physical therapy at this point in the treatment tableau. In addition, the ODG Guidelines do not support this request. The amount of physical therapy already received exceeds what is considered supportive from evidence-based guidelines. The reviewer upholds the previous adverse determination, and finds that medical necessity does not exist for Physical Therapy, 12 Sessions, 4x/week x 3 weeks.

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)**