

# US Decisions, Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW: AUGUST 2, 2008**

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical Therapy, 3x/week for 4 weeks (12 Sessions)

### **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, 3x/week for 4 weeks (12 Sessions).

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 6/26/08, 7/9/08

ODG Guidelines and Treatment Guidelines

MD, 12/7/07, 11/21/07, 4/1/08, 1/18/08, 7/14/08, 5/9/08, 4/9/08, 2/29/08, 2/15/08, 12/10/07, 6/1/8/08

Hospital Records, 4/1/08-4/2/08, 3/26/08, 4/1/08, 2/4/08, 1/21/08

Letter to IRO 7/22/08

Physical Therapy History at Hospital provided, Chart, Undated

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work-related injury on xx/xx/xx when he was injured while lifting a steel pipe and began having severe low back pain. He was diagnosed with a herniated disc at L3/L4 and L4/L5 and was taken to surgery where a large extruded fragment was found at L4/L5. This surgery was performed on 03/26/08. Postoperatively he began physical therapy, twelve sessions, beginning on 05/15/08 and continuing through 06/18/08. Current request is for twelve more sessions of physical therapy.

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

ODG Guidelines recognize sixteen sessions over a total of eight weeks post discectomy. The patient has already had twelve sessions and is now more than four months post surgery. The request for twelve additional sessions for a total of 24 exceeds ODG Guidelines. The reviewer finds that medical necessity does not exist for Physical Therapy, 3x/week for 4 weeks (12 Sessions).

**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)