

US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 6, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy/Aquatic Therapy

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/Aquatic Therapy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Concurrent Review Determinations, 05/15/08, 05/28/08

Office notes, Dr., 01/31/08, 03/20/08

Office notes, Dr., 04/08/08, 04/23/08

Office note, Dr., 04/30/08

Functional Capacity evaluation, 02/14/08

Work Conditioning summary, 03/14/08, 03/21/08, 03/28/08, 04/11/08

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back:
Physical Therapy

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year old male claimant reportedly had a long standing history of low back problems and was also treated for a severe second extensor compartment tenosynovitis. Examinations showed lumbar tenderness and limited lumbar range of motion. A lumbar MRI revealed L4-5 disc herniation. Conservative management included physical therapy/ aquatic therapy along with medications for the low back and injections and splinting for the tenosynovitis which gradually got better. The records indicated that the claimant had completed approximately twenty sessions of a work conditioning program. Work conditioning records indicated that the claimant made steady progress but still had poor body mechanics during squatting and lifting activity. A 04/30/08 physician record noted that the claimant had chronic intractable pain syndrome and continued conservative care was recommended in the form of medications and physical therapy and aquatics.

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

ODG guidelines suggest that physical therapy can be a useful adjunct for management of a variety of pathology in the lumbar spine. In this particular case, however, this individual would not present as a reasonable candidate. The records reflect that this individual suffered an injury in xx/xx and has been described as having chronic back complaints. The claimant has been through what appears to be an extended course of conservative care including 36 sessions of physical therapy as well as work conditioning. Historically, work conditioning has not shown proven benefit beyond the four-week range.

Based on the information available, and in consideration of ODG guidelines, there is no compelling case that additional physical therapy or aquatic therapy can be reasonably expected to offer this gentleman meaningful improvement in what appears to have been chronic ongoing back complaints subsequent to an injury more than a year earlier.

This patient does not appear to meet the medical necessity guidelines consistent with the evidence-based literature for physical therapy or aquatic therapy. Thus, the adverse determination for this request should be considered appropriate.

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)