

SENT VIA EMAIL OR FAX ON
Dec/23/2008

True Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/22/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
PT 3 X wk X 6 wks Lumbar

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Office notes, Dr , 09/18/07, 10/02/07, 10/09/07, 11/02/07, 12/04/07, 01/17/08, 04/04/08, 09/16/08, 10/30/08

X-rays lumbar spine, 09/20/07

Physical therapy evaluation, 12/4/07

MRI lumbar, 10/30/08

Peer review, Dr. 11/7/08

Peer review, Dr. , 11/26/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx year old male who fell 10-20 feet off a ladder and sustained an L2 burst fracture. On 09/19/07 he underwent L2 corpectomy with anterior fusion from L1-L3. He did well post op and returned to work. He had a course of physical therapy in December 2007.

On 04/04/08 the claimant complained of pain when working long days at his job. Neurological exam was normal. X-rays showed the instrumentation in good position, no evidence of subsidence of the cage. He was fused, completely healed from his L2 burst fracture. The claimant returned on 09/16/08 Dr. complaining of pain across the small of his

back. An MRI was ordered to evaluate for any disc injury. The 10/30/08 MRI of the lumbar spine showed annular tears at L4-5 and L5-S1 with no evidence of acute disc herniation. On 10/30/08 the claimant had a negative straight leg raise and normal motor and reflexes. The claimant was ordered L4-5 epidural steroid injection. Apparently eighteen visits of physical therapy were also ordered, which was denied on peer review.

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

The requested physical therapy, three times a week for six weeks, to the lumbar spine is not medically necessary based on a careful review of the medical records.

This claimant has undergone lumbar spine fusion following a burst fracture on 09/20/07. Postoperatively, he has seen Dr. a number of times, and the medical record documents normal neurologic evaluation without evidence of loss of motion, protective muscle spasm, or progressive loss of function. He has had physical therapy in the past, and although he has some increased subjective pain complaints at this time, he had an MRI that did not document significant lumbar abnormality.

ODG guidelines document the use of physical therapy, 10 visits over 8 weeks, in patients who have a new clinical condition or some underlying change, which does not appear to be the case in this claimant. His medical physician has not documented any objective abnormal physical findings, and no specific reason he could not be doing a home exercise program as directed by the ODG. Therefore, based on review of this medical record, there is no specific medical indication or necessity for the requested therapy at this time.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Low Back.

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial"

Lumbar sprains and strains (ICD9 847.2)

10 visits over 8 week

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8)

Medical treatment: 10 visits over 8 weeks

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)