

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 31, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy x 12 Sessions for the lumbar spine

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management

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 x 12 Sessions for the Lumbar Spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/7/08, 11/21/08

ODG Guidelines and Treatment Guidelines

, 11/3/08

Prescription, 12/11/08

Letter to IRO from Law Firm, 12/18/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx-year-old was injured in xx/xx. The material provided for review did not contain any physician notes and largely consisted of a therapy note from 11/3/08. This patient apparently had a hemilaminectomy and microdiscectomy in 11/07 and reportedly some postoperative therapy. The goals for the current request for therapy are to decrease pain.

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

There was very little information provided for this review. The therapist's record from November 2008 describes some prior treatment for this patient's prior back surgery. The ODG recommends post operative back therapy with 10 visits over 8 weeks following surgery. The treatment being requested is now more than one year post op, and therefore does not conform to the guidelines. There was no information provided for the reviewer to explain why any additional treatment is needed for this patient. The reviewer finds that medical necessity does not exist for Physical Therapy x 12 Sessions for the Lumbar Spine.

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)**