

US Decisions, Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 20, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3/wk x 4 wks

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 exists for Physical Therapy 3/wk x 4 wks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/4/08, 8/12/08

ODG Guidelines and Treatment Guidelines

Medicine Centre, 9/1/08, 8/19/08, 8/1/08, 8/11/08, 8/5/08, 7/17/08, 7/28/08, 9/19/08,

8/15/08, 8/12/08, 7/17/08, 7/11/08, 9/19/08

MRI of Lumbar Spine, 7/28/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker is reported to be lifting a heavy case while at work and sustained a back injury as a result. He is also reported to have had five sessions of physical therapy with improvement. His MRI scan reveals a protrusion of the right at L5/S1 with partial effacement of the right S1 nerve root, apparently 6 mm in AP dimension with associated

facet arthropathy and ligamentum flavum hypertrophy. There is a protrusion at the L4/L5 level. The patient's five treatments of physical therapy are reported to have given him benefit. The request is for twelve further sessions. The previous reviewer has noted that the ODG Guidelines recommends ten treatments of physical therapy for this type of problem. The patient has already had five. Further reviewer noted the patient should undergo some physical therapy, whereas the initial reviewer noted the patient should follow the ODG Guidelines of undergoing six treatments then being re-evaluated for determination of further therapy.

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

The denial of twelve additional treatments of physical therapy by the previous reviewers does conform to ODG Guidelines, and hence, it was reasonable to deny those treatments. The ODG recommends ten treatments. However, this particular patient has undergone just five treatments and has showed improvement, based upon the medical records provided.

As per TDI, this reviewer is not permitted to partially overturn this request, as it is a workers compensation case.

Therefore, this reviewer finds it necessary to diverge from the ODG guidelines and agree with the provider that twelve more treatments, three times a week for four weeks, are medically necessary. This patient has benefited thus far from the five treatments he has received, and it is this reviewer best judgment that in this case the patient certainly would benefit from additional physical therapy. It is with all of this in mind that the previous adverse determination is overturned. The reviewer finds that medical necessity exists for Physical Therapy 3/wk x 4 wks.

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)**