

SENT VIA EMAIL OR FAX ON
Jun/10/2009

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

DATE OF REVIEW:

Jun/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy three times a week for three weeks

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

Denial Letters 4/7/09 and 5/6/09

Spine 3/27/09

MRI 1/16/09

Specialty PT 9/30/08 thru 11/2/08

Dr. 12/8/08, 02/02/2009, 4/13/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury xx-xx-xx, when he bent over to reach a bottom file cabinet. His worst pain is in his thoracic spine. He has had 9 PT sessions with near normal range of motion. His neurological examination reveals decreased sensation in the bilateral C4-C5 distributions. He has atrophy of the entire right lower extremity (he has a history of polio). There is decreased sensation in the bilateral L4, L5-S1 distributions, right greater than left. An MRI of the lumbar spine 01/16/2009 reveals bulging discs at L3-L4, L4-L5, and L5-S1 with neuroforaminal narrowing bilaterally. An MRI of the thoracic spine 01/16/2009 is unremarkable. The ODG recommends up to 10 PT visits for acute and chronic injuries of the lumbar spine.

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

The PT is not medically necessary. The claimant has already had nine sessions of PT, which fulfills the ODG recommendation for lumbago. There does not appear to be any medically

necessary reason why his therapy cannot be transitioned to a home exercise program as recommended by ODG. There does not appear to have been a change in his neurological function. The requested PT is, therefore, not medically necessary.

References/Guidelines

2009 Official Disability Guidelines, 14th edition

“Low Back” chapter

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)