

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Twelve sessions of physical therapy to the low back

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

M.D., 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

Adverse Determination Letters/Peer Reviews, 09/18/09, 10/21/09
ODG Guidelines and Treatment Guidelines
Office note, PA-C, 05/06/09, 06/12/09
Office notes, Dr., 08/11/09, 09/24/09, 10/16/09
MRI lumbar spine, 08/18/09
Physical Therapy Daily Progress Notes: 08/19/09 through 09/04/09
Office note, PA-C, 08/20/09
Physical Therapy Re-evaluation Note, 09/09/09
Functional Capacity Evaluation, 09/11/09
DDE, Dr. 10/26/09
Job Injury Registration Form: xx/xx/xx
Prescription for FCE: 09/03/09
Prescription for Continued PT: 09/08/09
Laboratory Report – CMP: 09/24/09
Fund Forms; Patient Demographic Sheets x2
Database/Remarks Tracking sheets: 10/12/09; 10/16/09; 10/19/09

PATIENT CLINICAL HISTORY SUMMARY

This female sustained a low back strain and contusion to her left rib cage on xx/xx/xx . Documentation reveals a diagnosis of lumbago. A lumbar MRI performed on 08/18/09 demonstrated mild L4-5 central spinal stenosis and discogenic degenerative changes with

minimal L4 anterolisthesis associated with marked right-sided facet arthropathy. There was also mild facet arthropathy at L5-S1 bilaterally. The claimant underwent conservative care including multiple oral medications and physical therapy for complaints of continued low back pain with documentation of pain elicited on palpation in the 10/16/09 exam note.

A functional capacity evaluation completed on 09/11/09 demonstrated significant inconsistencies with reported unreasonably high levels of pain and exhibited limits in functional ability. Continued physical therapy was recommended if found to be beneficial with the claimant demonstrating response to therapy. Return to work modified duty was also recommended with restrictions in lifting to 22 pounds and limited standing and walking. A designated doctor's evaluation completed by Dr. on 10/26/09 determined the claimant had completed a course of physical therapy in line with the guidelines with documentation of improvement and increased mobility.

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

The request is for twelve sessions of physical therapy due to low back pain. Peer review note of 09/18/09 reflects claimant has had nine visits of therapy. The claimant is now greater than xxx months out from her injury with a diagnosis of lumbago/low back pain. At this juncture, and based upon the information reviewed, the ODG would not justify further active therapy, but rather a home exercise program, for lumbar stretching, strengthening and stabilization. The request for 12 sessions exceeds the number of recommended sessions in the guidelines. The reviewer finds that medical necessity does not exist for Twelve sessions of physical therapy to the low back.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates: Low Back – Physical therapy

ODG Physical Therapy Guidelines: Allow for fading of treatment frequency plus active self-directed home PT.

Lumbar sprains and strains: 10 visits over 8 weeks

Lumbago; Backache, unspecified: 9 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)