

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Nov/16/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Twelve sessions of Aquatic Therapy for the Lumbar Spine and Bilateral Hands using 97150 (1 unit per visit - 45 min) (3x/week x 4 weeks)

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

M.D., board certified in Orthopedic Surgery

**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, 10/8/09, 10/19/09

ODG Guidelines and Treatment Guidelines

Orthopaedic Surgery Group, 10/22/09, 10/19/09, 10/8/09, 10/5/09, 9/24/09, 9/10/09, 8/31/09, 8/24/09, 6/22/09, 1/8/09, 12/11/08, 11/14/08, 10/30/08, 10/24/08, 10/17/08, 10/13/08, 10/10/08, 10/9/08, 10/8/08, 10/6/08, 10/3/08, 10/1/08, 9/29/08, 9/26/08, 9/22/08, 9/18/08, 9/11/08,

Specialty Hospital, 8/27/09

MRI Lumbar Spine, 10/14/08

MRI Left Shoulder, 10/14/08

MD, 12/16/03, 10/14/03

MD, 5/10/09

Note, 2/6/09

Institute, 10/5/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female injured worker who was injured on xx/xx/xx. The patient underwent carpal tunnel release on 08/27/09. At six weeks post surgery the notes stated she was progressing nicely. There are records of previous physical therapy having been administered for this patient in 2008. The patient's diagnosis of lumbar spine would appear to be spondylosis. Current request is for aquatic therapy of twelve sessions.

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

As noted by the previous reviewers, a request for twelve therapy sessions exceeds the ODG Guidelines of ten sessions. Of note is that the patient has already had therapy. There is no firm diagnosis for the lumbar spine complaints, and the patient is greater than one year since injury. The requesting physician's have not explained why this request should be approved and why the ODG Guidelines should be set aside, given the wide deviation this request represents from those statutory-mandated guidelines. For this reason, the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Twelve sessions of Aquatic Therapy for the Lumbar Spine and Bilateral Hands using 97150 (1 unit per visit - 45 min) (3x/week x 4 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)