

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 2x/week x 6 weeks, Lumbar, 97110, 97140, 97530, G0283

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

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 9/2/09, 9/10/09
Office note, Dr. , 4/6/09, 04/30/09
MRI L/S, 4/17/09
Prescription, 7/29/09
Request for reconsideration, 8/3/09, 09/03/09
Office note, 8/13/09
PT request, 8/28/09
Peer review, Dr., 9/2/09, 09/10/09
Office note, Dr., 9/29/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male, injured on xx/xx/xx . He was treated for neck and back pain with a cervical fusion, therapy, and medications. His history was positive for a twenty-year history of smoking, obesity, previous lumbar laminectomy in 1989, anxiety, and depression. Current medications noted Cymbalta, Lyrica, Lidoderm patches and Suboxone, a synthetic opioid. Exam findings on 04/06/09 noted a positive right straight leg raise for pain in the right big toe and thigh. Left straight leg raise caused pain in the posterior thigh. Sensation was decreased over the medial aspect of the right lower extremity with numbness over the anterior thigh. Low back pain increased with forward flexion and extension caused right

lateral hip pain, right buttock and thigh pain. Lumbar MRI on 04/17/09 noted transitional S1 vertebrae, right sided L5-S1 disc herniation slightly more prominent than on a prior CT, prior right laminectomy, and left foraminal disc herniation L4-5 unchanged since a previous study. Weight loss along with a lumbar discogram, the McKenzie program and twelve sessions of physical therapy to include manual therapy and electrical stimulation was recommended.

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

The requested twelve visits of physical therapy cannot be justified based on the information provided for this independent review. The claimant's date of injury was three and one-half years ago. Records for xx/xx/xx indicate the claimant has received therapy in the past. The nature and extent of prior physical therapy is unclear. The response to previous therapy is also unknown, given the long duration of time since the claimant's injury. It is difficult to justify a formal physical therapy program at this time without further clinical information for the claimant. The request for physical therapy does not conform to the ODG Guidelines and Treatment Guidelines. The reviewer finds that medical necessity does not exist for Physical Therapy 2x/week x 6 weeks, Lumbar, 97110, 97140, 97530, G0283.

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

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT.

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8)

Medical treatment: 10 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)