

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/05/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy x 12 Sessions

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

MRI lumbar, 03/23/07

Office notes, Dr. 07/07/09, 08/12/09

Letter, Dr. 07/17/09

Office note, Dr. 08/18/09

Letter of medical necessity, Dr. 09/10/09

PATIENT CLINICAL HISTORY SUMMARY

This is a female claimant who reportedly sustained a back injury on xx/xx/xx while lifting a heavy cooler of food. The records indicated that the claimant had an exacerbation of back symptoms while performing her home exercise program. Provider records of July 2009 and August 2009 noted the claimant with lumbar spasm and tenderness with decreased range of motion. A previous lumbar MRI done in March 2007 reportedly showed a posterior central disc protrusion L4-5. Suggested conservative treatment included a return to physical therapy, hot packs and analgesic creams for massage. Twelve sessions of physical therapy were requested.

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

The treatment under discussion is for an injury over xxxx years old. There is no documentation of a new injury or some form of new physical findings to suggest that additional physical therapy would be necessary at such a late date. Based on the information

provided, I would agree with the determination of the carrier that the request for twelve sessions of physical therapy is not medically necessary. The request does not conform to the ODG. The reviewer finds that medical necessity does not exist for Physical Therapy x 12 Sessions.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, Low Back: Physical therapy (PT)

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.

Lumbar sprains and strains: 10 visits over 8 weeks

Sprains and strains of unspecified parts of back :10 visits over 5 weeks

Pain : Physical medicine treatment

Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of acute pain treatment or acute exacerbations of chronic pain and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries

Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels

ODG Physical Therapy Guidelines –

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

Myalgia and myositis, unspecified :9-10 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)