

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy three times per week for four weeks for the Lumbar Spine

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

MD, Board Certified Neurosurgeon

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, 10/22/10, 11/1/10

Micro Neurosurgery 8/27/10-10/25/10

Pain Management Center 4/10/10-10/21/10

DO 4/12/10-10/21/10

Patients Medical Center 8/19/10

Relief Medical 9/21/10

MRI & Diagnostic 4/22/10

Medical Care 3/4/10-3/22/10

Progressive Physical Therapy 3/22/10

Official Disability Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is male with a date of injury xx/xx/xx. He is status post redo of the right L4-L5 laminectomy and microdiscectomy 08/19/2010. He has undergone 12 sessions of physical therapy. He has improved, but continues with significant low back pain and gets recurrent leg pain with prolonged walking. He is on lortab. A note from 10/01/2010 states that he is completing home exercises on a daily basis. The request is for physical therapy three times per week for four weeks for the lumbar spine.

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

This claimant has undergone 12 sessions of physical therapy. Technically, 16 sessions are allowed by ODG post-discectomy. However, there are exceptional circumstances in this

case, in the sense that this is the third discectomy at the same level for this patient. It is clear from the records that he has made some functional gains with the recent physical therapy and is continuing a home exercise program. However, further gains may be made by additional therapy. Essentially, this would be an extra 8-sessions of PT than recommended by ODG for the patient's condition. However, the ODG does not address re-do discectomy post-operative conditions. Therefore, the reviewer finds that in this case there should be a divergence from the ODG, and the reviewer finds that medical necessity exists for Physical Therapy three times per week for four weeks for the Lumbar Spine.

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)