SENT VIA EMAIL OR FAX ON
Dec/30/2009

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy with aquatic and land therapy, modalities as needed for the lumbar spine 3 X 4

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

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Office note, Dr., 10/01/09
Office note, Dr., 11/09/09
Letter, Dr. 11/09/09
PT initial evaluation, 11/10/09
Denial Letters 11/19/09 and 12/2/09

PATIENT CLINICAL HISTORY SUMMARY
This is a male claimant who reportedly injured his lower back in xx/xx/xx while moving and lifting objects at work. The records indicated the claimant diagnosed with lower back pain syndrome, lumbar radiculopathy, lumbar disc herniation and chronic intractable pain syndrome. A physician record dated 11/09/09 noted the claimant with low back pain and left lower extremity pain. It was noted that the claimant had undergone previous physical therapy with no aqua therapy. Treatment options were discussed and aqua therapy was recommended. An 11/10/09 physical therapy evaluation revealed the claimant with low back pain due to L4-5 moderate central herniated nucleus pulpous and moderate to large L5- S1 central herniated nucleus pulpous. The claimant reported left foot numbness with prolonged standing and difficulty standing for prolong periods of time. An assessment revealed some limitations in range of motion, persistent pain / tenderness in the lumbar region and weakness in the lower extremity. Therapy records indicated that the claimant had had therapy in the past, which seemed to help. Rehabilitation potential was noted to be good with therapy

recommended two to three times a week for four weeks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
This case is a case of injury, which occurred over one year ago. Indeed, there has been therapy performed. The exact number of therapy visits provided is unavailable.

When one turns to the ODG guidelines, the interval for therapy treatment has long since passed in this case. The recommended 12 visits of aquatic and land therapy would not satisfy the guidelines for medical necessity at this time.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Low Back: physical therapy

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)