

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 2 x Wk x 6 Wks lumbar 97750 97110 97112 97530 97140 97035 97014

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

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates, Low Back
Request, spine care, 01/15/10, 02/24/10
Office note, Dr. 2/11/10
Prescription, 3/3/10
Request, 3/16/10
Peer Review, Dr. 03/23/10
CPT codes
Adverse Determination Letters, 3/10/10, 3/23/10

PATIENT CLINICAL HISTORY SUMMARY

This male completed approximately eleven sessions of therapy for an injury that occurred on xx/xx/xx. An office note from Dr. on 02/11/10 noted improvement in thoracic spine pain with tenderness at the thoracic lumbar junction and mid thoracic area. Neurovascular exam was intact with normal sensation and negative straight leg raise. The diagnosis was low back pain, unspecified, and thoracic spine disc degeneration. Continued therapy twice a week for six weeks for the lumbar spine with multiple modalities was requested.

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

The request for continued supervised physical therapy, twelve sessions, is not medically necessary. Limited clinical information was provided for review. No imaging studies have been submitted for review. The claimant has completed an appropriate amount of therapy for the diagnosis provided and the request would exceed the recommended amount per the ODG guidelines. There is insufficient recent clinical information to support the medical necessity for ongoing formal therapy for this injury. The reviewer finds that medical necessity

does not exist at this time for PT 2 x Wk x 6 Wks lumbar 97750 97110 97112 97530 97140 97035 97014.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates, Low Back

Lumbago; Backache, unspecified (ICD9 724.2; 724.5)

9 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)