

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

8 PT 97035 97110 97140 97530 97113 97116

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)

Ultrasound 97035 is not medically indicated and not appropriate.

Therapeutic exercises 97110 are reasonable and appropriate.

Gait training is reasonable 97116.

Aquatic therapy 97113 is not indicated.

Therapeutic activity 97530 dynamic activities are reasonable as is manual therapy 97140.

This is consistent with guidelines and based on the medical records.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Review: 10/18/10 and 10/25/10

Office Note, Dr. : 10/01/10

Prescription: 10/01/10

Therapy Note: 10/07/10

Fax Sheet: 10/13/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a reported low back injury on xx/xx/xx when he was struck by a forklift. Initial treatment records were not provided for review. The claimant had a diagnosis of chronic lumbalgia. Dr. evaluated the claimant on 10/01/10 with notation the claimant has continued to have pain since the last office visit. Notation was made that the claimant has not had physical therapy for several years. Dr. recommended a course of physical therapy to hopefully allow the claimant to return to work. The claimant was not considered a surgical candidate. A therapy evaluation was conducted on 10/07/10 with notation the claimant was not currently work, however, his current position did not involve lifting but the claimant did sit

in a truck for nine to ten hours. Notation was made that the claimant's recent onset of low back pain began approximately one year ago. The claimant complained of right side, low back pain with radiation of pain and numbness to the right lower extremity. The claimant treated with Celebrex. Reference was made to radiographs, without the findings noted. Physical examination demonstrated some difficulty with ambulation including negotiating stairs due to pain and weakness; guarded gait; lumbar and gluteal tenderness; right lower extremity weakness of -4/5; and negative straight leg raise. The claimant did not utilize an assistive device. Recommendation was made for physical therapy twice a week for four weeks with exercises, ultrasound, aquatic therapy and gait training.

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

Eight physical therapy visits are reasonable in this xx year-old male who has had chronic long-term lumbar spine symptomology and complaints. He has not had recent physical therapy as of 10/01/10 per Dr.. He is requesting lumbar stabilization program with core strengthening.

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This is consistent with guidelines and based on the medical records.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates; Low Back- Physical Therapy, Aquatic Therapy and Ultrasound- therapeutic.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates; Knee- 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

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)