

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy Thoracic Lumbar x8 vst 2xwk x4wks

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

MD, Board Certified Physical Medicine and Rehabilitation

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

Utilization review determination dated 08/22/11, 09/14/11

Plan of care dated 07/28/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xxxx. The patient fell while walking. Plan of care dated 07/28/11 indicates that the patient has been diagnosed with pain in thoracic spine, muscle weakness-general, and lumbago. The patient has completed at least 40 sessions of physical therapy. On physical examination lower extremity muscle testing is rated as 5/5 bilaterally. Muscle testing thoracolumbar planes is rated as +3/5 bilaterally.

On 08/22/11, the request for physical therapy was denied. The peer reviewer denied the request as the amount of PT visits allowed by ODG is 10-12 visits. If improvement is shown, the visits can be extended. The patient has undergone a total of over 40 visits of PT for different parts of the body. There is no documentation showing why home exercise is not an option for this patient. The denial was upheld on appeal on 09/14/11 noting there is no documentation of exceptional indications for therapy extension and reasons why an independent home exercise program would be insufficient to address any remaining functional deficits.

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

This patient sustained injuries in xx/xxxx and has undergone at least 40 sessions of physical therapy. There is no comprehensive assessment of treatment completed to date or how the patient has responded submitted for review. There are no serial progress notes provided to document the patient's progress in therapy completed to date in order to establish efficacy of treatment and support additional sessions. There is no current, detailed physical examination submitted for review. The patient's compliance with a home exercise program is not documented. The patient has completed sufficient formal therapy in accordance with the

Official Disability Guidelines. The reviewer finds that medical necessity does not exist for Physical therapy Thoracic Lumbar x8 vst 2xwk x4wks.

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)