

Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 817-549-0311

IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW: 7-7-2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3 x a week x 4 weeks Lumbar

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

Certified Chiropractor

AADEP Certified

Whole Person Certified

TWCC ADL Doctor

Certified Electrodiagnostic Practitioner

Member of the American of Clinical Neurophysiology

Clinical practice 10+ years in Chiropractic WC WH Therapy

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Request IRO form, IRO request and forms, TDI letter, pre-authorization 5-30-2007 and 6-7-2007, Care pre-authorization request, Exacerbation report from Care dated 5-22-2007, re-exam Care, Report Dr. 2-24-2003

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was injured in an occupational injury to the cervical and lumbar spine. The injured employee eventually fell under the care of Care. The injured employee eventually underwent several pain management injections. The injured employee was placed at MMI on 8-8-2002 by Designated Doctor and assigned a 10% IR. The injured employee reported back to Care on 5-22-2007 for an exacerbation of the lumbar spine. There is a significant gap in the records from the Designated Doctor exam until the visit at Care on 5-22-2007. It would appear the claimant has not complained nor underwent any therapy or treatment for this injury in the past several years. The injured employee apparently returned to Care on 5-22-2007, which initiated the request for 12 sessions of therapy.

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

The injured employee was injured and underwent advanced imaging and therapy. The injured employee underwent therapy and pain management injections. The injured employee was assessed at MMI and assigned a 10% IR. From the records reviewed it appears that the claimant has not undergone any therapy or treatment for the injuries in the past several years. The request is not supported by the guidelines with the current documentation reviewed.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)