

# True Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 214-276-1904

**DATE OF REVIEW:** 6-28-2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical therapy 3 x a week for 4 weeks Lumbar 97110, 97140, and 97350

**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

**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 7-4-07, LHL009 5-24-07, Letter from treating Dr regarding IRO, Exam consultation notes 4-20-07, 4-13-07, EMG 4-3-07, National Guidelines low back pain, Peripheral Nerve Injury information, FCE 3-13-07, denial letters from the URA 5-10-07 and 5-24-07.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was involved in an occupational injury. The injured employee was apparently lifting a sofa and injured her low back. The injured employee underwent therapy and eventually an EMG/NCV. She underwent 12 sessions of therapy, which was beneficial. The injured employee aggravated her injury as a result of her work activity. Therefore, the treating physician has requested 12 sessions of therapy.

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

The injured employee did in fact sustain an occupational injury . EMG/NCV revealed lumbosacral nerve root irritation. The injured employee was returned to work and aggravated her conditions. Requested therapy is within the guidelines for an exacerbation. Additionally, prior therapy was beneficial and the injured employee did progress under the current plan.

**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)**
  - NATIONAL AMERICAN SPINE SOCIETY