

SENT VIA EMAIL OR FAX ON  
Feb/17/2009

## True Decisions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/11/2009

**IRO CASE #:**

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

12 sessions of PT

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

A Chiropractor with 12 years of treating patients in the Texas Workers' Compensation system as a level II approved treating doctor

**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**

OD Guidelines

Denial Letters 12/2/08 and 12/23/08

Letter from Patient 9/4/06

MRI 6/30/08

Radiology Report 1/8/08

Records from Dr. 4/4/06 thru 8/12/08

Records from Spine and Rehab 5/2/07 thru 12/2/08

DDE 12/5/07

Peer Review 5/8/08

Record from Dr. 12/8/08

Record from Dr. 1/7/08

**PATIENT CLINICAL HISTORY SUMMARY**

This patient was injured on xx/xx/xx while working for xxxx as an xxxx. On this day he was exiting the rear of the van when the van door hit his forehead and hyper extended his neck. The records show a discrepancy in the complaints and nature of the injury.

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

The 12 sessions of physical therapy is not reasonable or medically necessary according to the below referenced criteria. At this point the patient no longer requires any conservative treatment. This patient has had two years of treatment with little or no improvement; there is no reason to expect a positive outcome from the requested services. The ODG does not allow for continued treatment with no improvement from previous care. Also, the designated doctor already found the patient to be at maximum medical improvement, requiring no further treatment. Therefore, the 12 sessions of physical therapy is not reasonable or medically necessary.

**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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)