

SENT VIA EMAIL OR FAX ON
Jul/28/2010

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3 X wk X 3-4 wks for cycling and aquatic exercises

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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 6/7/10 and 7/6/10
Border Therapy 6/1/10 thru 6/17/10
Ultrasound 12/9/09
Dr. 12/9/09
MRI 1/18/10
Rehab 1/18/10 thru 4/28/10
Neurospine 4/22/10
Electrodiagnostic Lab 5/5/10
El Paso 5/20/10 thru 6/9/10

PATIENT CLINICAL HISTORY SUMMARY

This is a woman reportedly injured on xx/xx/xx. She developed right medial thigh and lateral knee pain. No explanation was found. The lumbar MRI showed some degenerative changes, but these were not consistent with her physical complaints. The electrodiagnostic studies were normal. She had 3 corticosteroid injections without help. She had 15 therapy sessions at a therapy program with a Mr. and Mr. without improving. There is a request for 1 weekly cycle and twice-weekly aquatic therapy for 4 weeks.

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

The ODG approves therapy, but suggest reassessment if there is no improvement. There is no osseous or intraarticular injury. The ODG will permit up to 9 therapy sessions for nonoperative soft tissue knee injuries or hip injuries. Aquatic therapy is to be included in this

number. She exceeds this recommendation and has not improved. There was no information provided to suggest why a variance from this recommended treatment is advised. Therefore, the request is not 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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