

SENT VIA EMAIL OR FAX ON
Jan/08/2010

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Therapeutic Exercise; Neuromuscular Re-education; Manual therapy techniques; ea 15 min.

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 12/1/09 and 12/15/09

Pain & Recovery 11/11/09 thru 1/4/10

PATIENT CLINICAL HISTORY SUMMARY

This man sustained a work injury reportedly on xx/xx/xx. Dr. wrote that he had ongoing right foot pain and low back and an amputation of the tuft of the large toe.

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

Dr. stated the man needed additional therapy. The reviewer presumes he had some, but no records of a diagnosis for the back pain or the time of the toe amputation. Presumably, the toe amputation was at the time of the original injury. The ODG discusses therapy following toe reimplantation, but this is not appropriate. Treatment usually is WBAT and possibly a shoe filler. This rarely requires significant therapy. Allowing that Dr. talks about a stiff toe, we could possibly extrapolate to the treatment of hallux rigidus. This would encounter a total

of 9 visits over 8 weeks. The request is for an additional 12 sessions and appears excessive in the absence of additional information.

In the absence of more information, the reviewer presumes the low back pain is nonspecific as a lumbago. The ODG advises first 6 therapy visits reduced from thrice to once weekly, or a total of 9 visits over 8 weeks. This again is less than the additional 12 sessions requested. Without specific reasons why this man had not improved, the reviewer agrees with the URA.

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)