

SENT VIA EMAIL OR FAX ON
Jun/24/2010

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy Cervical Spine X 12 sessions; 4 units per session; Joint Mobilization Cervical Spine X 12 sessions, 1 unit per session; Electrical Stimulation Cervical Spine X 12 sessions, 1 unit per session; Myofascial Release Cervical Spine X 12 sessions, 1 unit per session

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

AADEP Certified
Whole Person Certified
Certified Electrodiagnostic Practitioner
Member of the American of Clinical Neurophysiology
Chiropractor Physician
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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 4/28/10 and 5/13/10
Cervical CT 1/5/10
MRIs 1/5/09, 9/29/08, 8/4/09
EMG/NCS 9/21/09
Cervical Spine 12/17/08
Spine & Rehab 4/13/10 thru 6/4/10

IRO Summary 6/8/10
Bone and Joint 6/25/09 thru 1/19/10
Initial Diagnostic Screening 12/9/09
FCE 1/13/10
Treatment Notes 1/19/10 thru 3/4/10
Dr. 4/28/10 and 5/12/10
PPE 5/21/10

PATIENT CLINICAL HISTORY SUMMARY

The injured worker was injured on xx/xx/xx. The injured employee injured when she was lifting a 24-pack of water and felt neck pain and right shoulder pain. The injured employee underwent a CT scan, x-rays, MRI, EMG/NCS, cervical epidural, physical therapy 2x per week for 3 months, psychological evaluation and treatment, PPE, FCE, DME brace, Neuromuscular stimulator, bone stimulator, seat attached walker, and medication. The injured employee eventually underwent a cervical fusion on 2-04-2009 with post-operative therapy and home exercise. Twelve (12) sessions of physical therapy are now being requested for an exacerbation of symptoms during home exercise.

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

The injured employee is over 1-year post surgery and has completed post-operative therapy and has been performing home exercises. There is no significant medical evidence submitted that would require going outside the OD Guidelines of 24 visits over 16 weeks.

ODG Physical Therapy Guidelines

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)