

I-Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: January 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy of three times a week for four weeks

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

MD, Board Certified in Physical Medicine and Rehabilitation

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

Utilization Review Findings, 12/2/10, 12/13/10

Care Programs, Inc. 10/20/10 to 11/22/10

Physical Medicine Treatment History 12/16/10

Care Programs, Inc. 11/22/10

Pain Consultants 5/27/09 to 11/17/10

Dr. 4/1/06

M.D. 8/10/09

M.D. 11/17/06

Diagnostic Imaging 1/17/08

Orthopaedic Center, PA 4/3/06

MRI 6/23/04

ODG-TWC

PATIENT CLINICAL HISTORY SUMMARY

This is a man was injured in xxxx. He sustained a rotator cuff injury and a fracture of the coccyx. The latter healed. There is a spreadsheet of the therapies he received. He manages on hydrocodone, tramadol and cyclobenzaprine. He apparently had an accentuation of his pain in the Fall of 2010. He was diagnosed with stomach cancer in the Spring of 2010. He has been getting aquatic therapy with some reduction in his pain. The request is for Physical Therapy of three times a week for four weeks which has been denied twice by peer reviewers.

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

The records provided contained a spreadsheet of therapies provided from 2004 through 2009 including work hardening and chiropractic care. This patient appears to have had 6 sessions

of aquatic therapy in November 2010. Twelve (12) more sessions have been denied on peer review. There does not appear to be any new injury. It was noted by Dr. that he is having chronic back pain and the old fracture of the coccyx. I could not determine if this pain is general back pain or specific to the coccyx. In either case, the ODG allows up to 10 sessions of therapy after an acute injury. The amount of therapy requested exceeds the amount for an acute condition. There were no reasons provided to justify a variance from the criteria provided in the ODG to justify the additional treatment as being medically necessary. The reviewer finds that medical necessity does not exist for Physical Therapy of three times a week for four weeks.

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)