

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/30/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 PT 3 X 4 wks lumbar spine

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

Neurosurgery

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

Utilization review determination dated 10/09/12, 11/02/12

Letter dated 02/17/12

Script dated 10/03/12

Initial evaluation dated 10/03/12

Plan of care dated 10/03/12

Neurosurgery office/clinic note dated

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was pulling =. He states that he fell to his side and immediately began experiencing essentially right sided hip pain. He said that over time this localized to his back and he has had worsening back pain over the years. The patient underwent right knee arthroscopy in 2009 followed by right total knee replacement in 2010. Initial evaluation dated 10/03/12 indicates diagnoses are displacement of lumbar intervertebral disc without myelopathy; and lumbago. Lumbar flexion and bilateral side gliding is within normal limits. Extension is reported to be moderate. Right lateral flexion is moderate, and left lateral flexion and bilateral rotation is minimal.

Initial request for PT 3 x 4 wks was non-certified on 10/09/12 noting that the patient has had appropriate PT in the past and this is an exacerbation. ODG does not recommend therapies

97014, 97012, 97112 and 97150 to be used for the treatment of the patient's lumbar dysfunction/disorder. The denial was upheld on appeal dated 11/02/12 noting that the request as stated exceeds the recommended treatment guidelines for the recommended number of treatment modalities. In addition, the request as stated contains CPT codes which are passive modalities and outside guidelines.

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

Based on the clinical information provided, the request for 12 PT 3 x 4 wks lumbar spine is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. It is unclear how many sessions of physical therapy the patient has completed to date. The patient sustained injuries in March 2008; however, the earliest record submitted for review is from October 2012. The request exceeds recommendations set forth by the Official Disability Guidelines. The patient's compliance with an active ongoing home exercise program is not documented.

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)