

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Six sessions of Physical Therapy only for the Cervical Spine

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

PM&R and Pain Medicine

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
Utilization review determination dated 05/03/13, 06/17/13
Physical therapy initial examination dated 04/22/13
Progress note dated 05/09/13
Letter dated 05/15/13
Appeal letter dated 05/09/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient tripped and fell against a brick wall injuring her neck and right shoulder. Physical therapy initial examination dated 04/22/13 indicates that cervical active range of motion is forward bending 30, backward bending 20, right rotation 30, left rotation 35, and bilateral side bending 25 degrees. Motor strength is rated as 4-/5 in cervical flexion and 4/5 cervical extension, cervical side bending and cervical rotation. Progress report dated 05/09/13 indicates that the patient's left shoulder pain has entirely resolved. The patient is working modified duty. Current medications are Tramadol, Zestril, Celebrex, Lipitor, albuterol, Zocor, metformin and Advair. On physical examination strength is 5/5 in the bilateral upper extremities. Deep tendon reflexes are 2+ bilaterally. Sensation is grossly intact. Diagnoses are contusion/strain of cervical spine and thoracic spine; and history of left shoulder contusion, resolved.

Initial request for six sessions of physical therapy was non-certified on 05/03/13 noting that the patient's diagnosis is at best a contusion or sprain/strain. These conditions have long

ago resolved. There is no indication for PT almost 6 weeks later. Appeal letter dated 05/09/13 indicates that the patient has not received any physical therapy to date. The denial was upheld on appeal dated the patient has already undergone at least 6 sessions of formal therapy. The ODG would allow up to 10 sessions of formal therapy. Passive treatment was proposed which would not be consistent with ODG criteria.

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

The patient sustained a contusion or sprain/strain injury to the cervical spine in xx/xxxx. This condition should have resolved at this time with or without treatment. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. It is unclear if the patient has undergone prior therapy, and if so, the patient's objective functional response is not documented. As such, it is the opinion of the reviewer that the request for six sessions of physical therapy only for the cervical spine is not recommended as 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)