

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/21/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 Sessions of Physical therapy for the Lumbar 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 04/09/13, 05/06/13

Handwritten note dated 05/02/13, 04/01/13

Initial evaluation dated 04/01/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped while carrying an object. The patient was seen by a chiropractor. Initial evaluation dated 04/01/13 indicates diagnosis is lumbosacral sprain. The patient is working light duty. On physical examination pain is rated as 7/10 with activity and 0/10 at rest. Patient is very tender and there is significant muscle guarding and deep spasm in the paraspinals to palpation. Lumbar flexion is 30 and extension 10 degrees. Strength is rated as 3-/5. Note dated 05/02/13 indicates that when he is walking he feels a pinch.

Initial request was non-certified on 04/09/13 noting that claimant has had chiropractic care in the past. There is no indication for physical therapy for an incident on xx/xx/xx. The denial was upheld on 05/06/13 noting that it is documented that past treatment did include an attempt at treatment in the form of chiropractic treatment. For the described medical situation, the reference would typically support an expectation for an ability to perform a proper nonsupervised rehabilitation regimen when an individual is this far removed from the onset of symptoms and when previous treatment has included an attempt at treatment in the form of supervised rehabilitation services. There is no documentation of a focal neurological deficit on physical examination.

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

The patient sustained injuries in xx/xx; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient's compliance with an ongoing active home exercise program is not documented. The patient's diagnosis is reported to be a lumbosacral sprain which should have resolved at this time. As such, it is the opinion of the reviewer that the request for 12 sessions of physical therapy for the lumbar 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)