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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/03/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 12 PT/Aqua therapy sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified PM&R and Board Certified 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. It is the opinion of the reviewer that the request for 12 PT/Aqua therapy sessions is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 02/04/13, 03/05/13
Letter dated 04/15/13, 04/18/13
Preauthorization request form dated 01/31/13, 02/22/13
Appeal letter dated 02/21/13
Plan of care dated 01/30/13
Office note dated 01/11/13
Script dated 01/14/13
Initial evaluation dated 01/30/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. The earliest record submitted for review is dated 01/11/13. The patient is now getting a bit more neck pain and this is bothersome to her. She feels in her left arm is continuing to improve slowly, but the gains that she makes are much better when she is involved with therapy. Prior to her stimulator surgery, she had epidural steroid injections and facet injections that did not seem to help things. She has had no injections recently. On physical examination gait and station are normal. She still has sensory changes in her left arm and hand. Her reflexes are symmetrical. Spurling's sign is negative bilaterally. Diagnoses are cervical spondylosis without myelopathy; and displaced cervical intervertebral disc. Initial evaluation dated 01/30/13 indicates that the patient's history is significant for C5-6 fusion in 2008. Neurostimulator that failed resulted in hemiplegia in October 2010. Cervical range of motion is extension 70, flexion 40, right rotation 58, left rotation 48, bilateral side bend 40 degrees.

Initial request for 12 PT aqua therapy sessions was non-certified on 02/04/13 based on the

diagnosis and the very chronic nature of the condition and the lack of any detailed discussion of number of prior PT sessions and sustained functional improvement and considering request is for extensive 12 additional sessions without new hard clinical indications. The denial was upheld on appeal dated 03/05/13 noting that clinical documentation provided for review notes the claimant complaining of cervical spine pain with associated functional deficits manifested by strength deficits. Official Disability Guidelines recommend 10 physical therapy sessions for an injury of this nature. Clinical documentation details the claimant previously completing 64 physical therapy sessions to date. This request exceeds guideline recommendations as no exceptional factors were noted in the clinical documentation. Additionally, given the completion of a full course of physical therapy, it would be reasonable to expect the claimant to progress to a home exercise program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in June 2007. The mechanism of injury is not described. The earliest record submitted for review is from January 2013. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. It is difficult to obtain a clear picture of the patient's treatment and condition given the lack of extensive documentation. The patient has reportedly undergone extensive prior treatments to include physical therapy; however, there are no treatment records provided. The patient's compliance with an ongoing home exercise program is not documented. As such, it is the opinion of the reviewer that the request for 12 PT/Aqua therapy sessions 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)