

True Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jun/30/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

8 visits of physical therapy to the neck and low back

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

Board Certified Orthopedic Surgery

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped and fell at work. Initial evaluation dated xxxxx indicates that the patient was referred to physical therapy for evaluation and treatment of cervical and lumbar pain. He is currently taking Tylenol for pain. On physical examination strength is +3/5 to 5/5 in the lower extremities. Cervical range of motion is limited. Lumbosacral range of motion is limited. Diagnoses are cervicgia and lumbago.

Initial request for 8 visits of physical therapy to the neck and low back was non-certified on 05/12/14 noting that the patient has received an unspecified number of visits of physical therapy for this injury. Therefore, the requested additional visits are more than recommended by the cited criteria. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. The denial was upheld on appeal dated 05/21/14 noting that 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, and the patient's subjective functional response to this treatment is not documented to establish efficacy of treatment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND

CONCLUSIONS USED TO SUPPORT THE DECISION:

The patient sustained injuries in xx/xxxx. There is no documentation of treatment completed to date. The number of sessions of physical therapy the patient has completed over the years is not documented. There is no documentation of significant and sustained gains as a result of previous physical therapy. The patient's compliance with an active home exercise program is not documented. The Official Disability Guidelines would recommend transition to an independent, self-directed home exercise program at this point in the patient's treatment. As such, it is the opinion of the reviewer that the request for 8 visits of physical therapy to the neck and low back 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)