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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

June/2/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy Medical Procedure on 11/19/13

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

Board Certified PM&R

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. Treatment to date is noted to include cervical fusion, physical therapy, work hardening program and chronic pain management program. Note dated 07/26/13 indicates that the patient has a history of C3 through C6 ACDF performed prior to his work injury. The patient sustained a contusion/sprain/strain of the neck and right shoulder on the date of injury. The last PPE reportedly demonstrates the patient to be functioning at a light-medium PDL. However, he has a very heavy work requirement. Note dated 11/15/13 indicates that the patient requires continued medication reduction, this more readily facilitated through the application of 20 sessions of chronic pain management program. The patient subsequently underwent a physical performance evaluation on 11/19/13. Current PDL is listed as light-medium and required PDL is medium.

Initial request for physical therapy medical procedure on 11/19/13 was non-certified on 01/14/14 noting that the claimant continued to have moderate to severe symptoms despite taking narcotic pain medication and undergoing a chronic pain treatment program. He has not returned to work since his injury (no plans for his return to work in the future were noted in the chart).

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

The patient sustained injuries in xx/xxxx and has not returned to work since that time. The patient has completed extensive treatment to date including a work hardening program and a chronic pain management program. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program. Per follow up note dated 07/26/13, the last PPE demonstrated the patient to be functioning at a light-medium PDL. It is unclear when the prior PPE was performed. Note dated 11/15/13 indicates that the patient requires continued medication reduction, this more readily facilitated through the application of 20 sessions of chronic pain management program. Given that the patient had not returned to work, the fact that the patient had previously completed a chronic pain management program and there is no indication that the patient is planning to return to work, there is no clear rationale provided to support the physical performance evaluation performed on 11/19/13. As such, it is the opinion of the reviewer that the request for physical therapy medical procedure on 11/19/13 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)