Independent Resolutions Inc.
An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (682) 238-4977
Fax: (888) 299-0415
Email: carol@independentresolutions.com

IRO REVIEWER REPORT

Date: 2/5/2018 2:26:34 PM CST

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy Cervical, Thoracic, Lumbar

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

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☐ Partially Overtuned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XX-year-old XX with history of an occupational claim from XXXX. The mechanism of injury is XXXX. According to the XXXX cervical MRI there is straightening of the normal cervical lordosis seen with muscle spasm. At C2-3 there is a 2 mm disc herniation of mild spinal canal stenosis; C3-4 and 1–2 mm disc herniation with mild spinal canal stenosis and mild left greater than right neuroforaminal narrowing; at C4-5 2 mm disc herniation and right foraminal disc protrusion with mild spinal canal stenosis and moderate right and mild left neuroforaminal narrowing; C5-6 disc herniation superimposed left lateral recess disc protrusion measuring up to 3 mm abutting and deforming the left ventral spinal cord with mild spinal canal stenosis and moderate left greater than right neuroforaminal narrowing; C6–71 mm disc herniation and mild bilateral neuroforaminal narrowing. Lumbar MRI revealed edema in the L4-5 interspinous space; increase fluid and L5-S1 facet joint and L4-5 broad-based disc herniation measuring up to 5 mm in AP dimension with a tear of annulus fibrosis. The XXXX medical history and chief complaint check off sheet indicates the patient had reduced range of motion in the cervical and lumbar spine with pain. There were bilateral myofascial trigger points in the suboccipital, cervical, scalene, sternocleidomastoid, trapezius, levator scapula, thoracic paraspinal, middle trapezius, rhomboid, lumbar erector spinae, quadratus lumborum, gluteal and piriformis muscles. Orthopedic tests revealed a right maximal cervical compression, bilateral shoulder depressor and right cervical/thoracic Soto Hall test. There is a positive Kemps in the lumbar spine. The patient had bilateral straight leg raise, Braggards and Yeomans. The patient had a positive milligrams and left Fabere test. The patient was recommended therapy 3 times a week for 4 weeks.

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

The Official Disability Guidelines state physical therapy is recommended. A “six-visit clinical trial" is recommended when physical therapy is being initiated with a total of 10 visits over 8 weeks for sprains and strains of the neck and lumbar spine. In this case, there were no objective range of motion deficits identified, nor was the strength addressed. The patient was recommended therapy 3 times a week for 4 weeks. While there are deficits identified, the request as submit is not supported by the guidelines nor the documentation. As such, the prior determination is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

1. Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Neck& Upper Back, Physical therapy (PT) 2. Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Low Back, Physical therapy (PT)