

P-IRO Inc.

An Independent Review Organization

835 E. Lamar Blvd., #394

Arlington, TX 76011

Fax: 866-328-3894

Notice of Independent Review Decision

DATE OF REVIEW: 12-27-2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3x4, (12 sessions)

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

Chiropractor

AADEP Certified

Whole Person Certified

TWCC ADL Doctor

Certified Electrodiagnostic Practitioner

Member of the American of Clinical Neurophysiology

Clinical practice 10+ years in Chiropractic WC WH Therapy

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

No ODG Guidelines

Adverse Determination Letters-11/6/07; 12/3/07

Carrier notes RN-11/2/07-12/3/07

Healthcare Associates Pre-auth request-11/2/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee was involved in an occupational injury on xx/xx/xx. The injured employee sustained a crush injury to the right foot/little digit. The injured employee underwent an initial surgery with skin graft on 1-07-2007 and a follow-up surgery on 7-07-07. It appears that the injured employee had undergone 3 weeks of therapy starting around 4-07-2007, which apparently was not helpful and eventually underwent the follow-up surgery on 07-07-07. It does not appear from the records reviewed that the injured employee had undergone any post-surgical therapy after the 07-07-07 surgery.

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

The injured employee had undergone a second surgery on 07-07-07 and it does not appear from the records that were reviewed that any post-surgical therapy was performed. Therefore, in view of this and the currently OD Guidelines the injured employee does meet the criteria for the requested 12-sessions of therapy.

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
- 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)**