



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

Workers' Compensation Health Care Non-network (WC)

12/13/2007

DATE OF REVIEW: 12/13/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3 times a week for 4 weeks

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

Texas State Licensed MD Board Certified Orthopaedic Surgeon

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to 11/26/07
2. Texas Dept of Insurance Notice of Assignment to Utilization Review Agent 11/26/07
3. Confirmation of Receipt of a Request for a Review by an IRO 11/19/07
4. Company Request for IRO Sections 1-8 undated
5. Request for a Review By an IRO 11/16/07
6. Reconsideration of Medical Determination 11/09/07
7. Notification of Determination 10/29/07
8. office note 11/17/07
9. Physical Therapy order 11/17/07
10. Appeal of Pre Auth Request 11/8/07-12/14/07
11. Letter from 10/31/07
12. Pre auth request 10/23/07
13. PT referral form 10/16/07
14. Therapy Prescription 10/16/07
15. PT order 10/16/07
16. PT re-evaluation 10/11/07



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17. office note 10/2/07
18. Medical Imaging MRI report 9/14/07
19. Medical Imaging CT Scan report 9/14/07
20. procedure order 8/14/07
21. MRI/CT order 8/14/07
22. office note 8/14/07
23. PT re-veal 08/21/2007
24. PT initial eval 08/01/2007
25. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

I have carefully reviewed the records. This patient sustained injury on xx/xx/xx. He subsequently sustained injury to his low back, elbow, radius and ulna. Dr. carried out surgery on July 17, 2007. After healing of his fracture he was sent for physical therapy. This included soft tissue mobilization, ultrasound and electrical stimulation. That therapy was primarily directed to the upper extremity. He had a reevaluation on physical therapy on October 11, 2007. At that time he still had a 10 degree flexion contracture and still had only 80% range of motion of his finger. To date, he had not received physical therapy to his lumbar spine. He has been under the care of Dr. for his low back. Dr. has recommended physical therapy. I concur with the recommendation made by Dr. for further physical therapy.

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

It would be reasonable for this individual to have an additional four weeks of therapy. It would be reasonable for him to attend physical therapy 2-3 times per week during those four weeks. The referral for physical therapy is in keeping with medical practice in the community and recommendations made by the American Academy of Orthopedic Surgery and North American Spine Society.

Physical therapy three times a week for four weeks is medically necessary to treat a lumbar soft tissue injury.

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



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- 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)**