

## IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 02/20/07

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical medicine/rehabilitation three times a week for four weeks

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

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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

A CT scan of the cervical spine interpreted by (no credentials were listed) dated 09/01/06

Evaluations with dated 09/06/06, 09/13/06, and 10/25/06

Evaluations with an unknown physical therapist (the signature was illegible) dated 09/07/06, 09/20/06, 10/11/06, and 10/25/06

Physical therapy with the unknown therapist dated 09/07/06, 09/11/06, 09/13/06, 09/18/06, 09/20/06, 09/25/06, 09/27/06, 10/02/06, 10/04/06, and 10/11/06

A physical therapy authorization form from an unknown provider (no name or signature was available) dated 09/11/06

Evaluations with (no credentials were listed) dated 09/20/06, 10/04/06, 11/03/06, and 11/17/06

MRIs of the right shoulder and lumbar spine interpreted by dated 10/10/06

An evaluation with (no credentials were listed) dated 10/11/06

Evaluations with dated 10/20/06, 11/08/06, and 11/29/06

Therapy referral forms from dated 10/20/06 and 11/08/06

Letters of non-authorization from dated 10/27/06, 11/22/06, 01/12/07, and 01/18/07

An evaluation with dated 12/27/06

A DWC-73 form from dated 01/25/07

A letter of denial from and dated 02/01/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

A CT scan of the cervical spine interpreted by on 09/01/06 revealed multilevel and multifactorial degenerative changes. On 09/06/06, recommended ice, Celebrex, Skelaxin, Lortab, and physical therapy. Physical therapy was performed with the unknown therapist from 09/07/06 through 10/11/06 for a total of 10 sessions. On 10/04/06, recommended an MRI of the right shoulder and lumbar spine and continued Lortab. MRIs of the right shoulder and lumbar spine interpreted by dated 10/10/06 revealed a type II acromion, mild capsular hypertrophy of the AC joint, mild supraspinatus tendinosis, and mild bursitis. On 10/20/06, injected the right shoulder and recommended physical therapy and a non-steroidal anti-inflammatory. On 10/25/06, recommended Skelaxin, Celebrex, and Ultram. There were four letters of non-authorization for physical therapy from from 10/27/06 through 01/18/07. On 11/08/06, continued to recommend physical therapy. On 11/17/06, also recommended further physical therapy. On 11/29/06, felt the claimant was at Maximum Medical Improvement (MMI). On 12/27/06, recommended physical therapy three times a week for four weeks. On 01/25/07, filed a DWC-73 form stating the claimant could work light

duty with restrictions through 02/22/07. On 02/01/07, there was another letter of denial for further physical therapy from.

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

ODG Guidelines indicates that up to ten visits would be appropriate in this type of patient. At this time, the patient should be well informed in a home exercise program that she should institute herself on an as needed basis. The medical records do not support the need for the requested three times a week for four weeks.

**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 AND KNOWLEDGE BASE
- 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)**