



# PROFESSIONAL ASSOCIATES

## Notice of Independent Review Decision

**DATE OF REVIEW:** 06/18/07

**IRO CASE #:**

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

Physical therapy 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 Neurology

### **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**

An evaluation with M.D.

Evaluations with M.D. dated 05/03/06, 07/19/06, 11/09/06, and 01/23/07

A psychological evaluation with an unknown provider (no name or signature was available) dated 08/03/06

A Functional Capacity Evaluation (FCE) with M.Ed. and P.T. dated 10/31/06

A request note from Dr. dated 02/02/07

A letter of precertification request from L.V.N. dated 02/09/07

A letter of non-certification from Medical Department dated 02/12/07

A letter from the patient dated 02/20/07

Another letter of non-certification from TDI dated 05/17/07

A request for reconsideration of adverse determination dated 05/21/07

A Notice of Assignment of IRO dated 05/24/07

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

Dr. recommended a cervical spine surgery. On 07/19/06, Dr. recommended a work conditioning program. On 08/03/06, an unknown physician recommended a chronic pain management program. An FCE with Mr. and Ms. dated 10/31/06 revealed the patient would benefit from strengthening and conditioning. On 02/02/07, Dr. requested physical therapy three times a week for four weeks. On 02/12/07 and 05/21/07, there were letters of non-certification for physical therapy.

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

The requested physical therapy three times a week for four weeks is not reasonable or necessary as related to the original injury. As stated in the previous non-certification preauthorizations, the patient has already reached the Official Disability Guidelines normative value of therapy visits for this diagnosis. Passive physical therapy including passive exercises, electrical stimulation, massage, and ultrasound would not be medically indicated for this type of injury occurring seven years later. This does not meet the Official Disability Guidelines treatment criteria.

### **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)