

# IRO Express Inc.

An Independent Review Organization

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## **DATE OF REVIEW:**

*June 14, 2007*

## **IRO CASE #:**

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

*Fifteen sessions of physical therapy*

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

*DOCTOR OF CHIROPRACTIC-11 years of treating patients in the Texas Worker's Compensation system as a level II approved doctor, injury prevention consultant for Future Industrial Technologies (Backsafe/Sittingsafe).*

## **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**

*Notes from DC dated 3/07/07, 4/23/07, MRI right shoulder and left elbow dated 4/26/07, and upper extremity NCV/EMG notes and notes from MD dated 5/01/07.*

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

*This patient injured his right shoulder and left elbow while assembling some older heating units. He was placing screws in the heater core and was pushing and applying pressure with his arms and shoulder and began to feel pain in his right shoulder and left elbow.*

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

*All of the services in dispute are not reasonable or medically necessary according to the below referenced criteria. This patient had 18 visits of treatment with apparently little or no improvement. It is not reasonable to expect a positive outcome at this point in care. An additional 15 visits at this point would only create doctor dependency, somatization, chronicity and possible over utilization. It also appears that no self directed home exercise program was implemented. Therefore, the services in dispute are not reasonable or medically necessary.*

**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)**