

DATE OF REVIEW: 03/13/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient physical therapy two 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 chiropractor on the TDI-WC approved doctor's list that is familiar with the treatment or proposed treatment.

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.

It is determined that the outpatient physical therapy two times a week for four weeks is medically necessary to treat this patient's condition

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Information provided by the requestor:

None

Information provided by the respondent:

- Request form for IRO – 02/08/2007
- IRO request from Dr. – 01/08/2007
- Notice of Intent to Issue an Adverse Determination – 12/18/06
- Notice of Utilization Review Findings – 12/19/06, 01/04/07
- Letter to patient – 12/19/06, 01/04/07
- Pre-authorization PEER Review Form, p.2 – not date
- Precertification Form– 11/06/06,12/13/06
- Doctor's office notes – 11/02/06 to 12/13/06
- Request for Reconsideration from Dr. – 12/21/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on when he was involved in a motor vehicle accident resulting in pain to the neck and mid back. The patient has been treated with chiropractic care as well as physical therapy.

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

The medical record documentation confirms that this patient had injuries to both the cervical and thoracic spine. There is a continuation of subjective and objective findings revealed in the daily notes and reports and there is sufficient documentation to clinically justify an additional 8 visits at a frequency of 2 times a week. The 8 sessions of therapeutic exercises, manual therapy, and electric stimulation will allow this patient to obtain maximum improvement and after completion of the visit, he can progress to a home exercise program.

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)