

IRO America Inc.

DATE OF REVIEW:

MARCH 28, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3x per week for 4 weeks 12 sessions including Moist Heat, Ultrasound, Evaluation, Therapeutic Exercise, Manual Therapy

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

Certified

Whole Person Certified

TWCC ADL Doctor

Certified Electrodiagnostic Practitioner

Member

Clinical practice 10+ years in Chiropractic WC WH Therapy

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

Request IRO form 3-15-2007, Online IRO request 3-07-2007, denial for request dated 2-26-2007 and 3-07-02007, Notice to IRO TDI 3-09-2007, Professional Therapy Services script 12 sessions dated 2-20-2007, Kinetic flow sheet dates 2-08-2007 through 2-21-2007, Physical therapy evaluation 2-20-2007, Daily progress notes 2-12-07 through 2-21-2007, Summary of evaluation PTS 2-08-2007, PTS evaluation 2-08-2007, Medical information questionnaire & evaluation dated 2-08-2007

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient was involved in a MVA and injured his right wrist, hand, and lower forearm. The Patient apparently underwent about 5 sessions of therapy.

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

The Reviewer agrees that the services listed above are medically necessary; however, the reviewer agrees that a total of 12 sessions are not medically necessary. The review agrees that 9 sessions of physical therapy are 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)