



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 5/8/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of physical therapy (97110 & 97530) three times per week for three weeks.

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

The reviewing physician is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation and has greater than five years of experience.

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)

The reviewer agrees with the previous adverse determination regarding all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the injured employee, Dr., and Injury and from the carrier. The records consisted of the following: lumbar MRI of 3/14/06, thoracic MRI of 11/21/06, neurodiagnostic testing of 2/28/97 through 10/14/06, 7/15/05 RME by MD, FCE of 7/28/06 by PT, notes from MD from 11/6/02 through 3/7/07, notes from MD from 2/17/97 through 8/27/02 and 7/28/06 report from MD.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a woman who was injured while unloading Xerox paper. She developed neck and back pain as well as bilateral arm and shoulder pain. She

was treated with shoulder injections and eventually had cervical surgery in August of 2004. During a visit on 1/11/07, Dr. prescribed passive therapeutics including heat, massage and ultrasound as the patient had fallen prior to this visit.

She was most recently examined by her treating doctor, MD on 3/7/07 according to the records reviewed. His presumptive diagnoses are HNP C4/5, cervicalgia, L5/S1 HNP and lumbago. Based upon these findings, he recommended physical therapy.

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

The reviewer indicates that the physical therapy that is being recommended cannot be supported as being medically necessary as it relates to the injury. The Official disability Guidelines do not recommend physical therapy after a period of ten years post injury; therefore, the requested service cannot be approved at this time.

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)**