

Notice of Independent Review Decision

DATE OF REVIEW: 11/28/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3 x week x 4 weeks (12 sessions)

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

The TMF physician reviewer is a licensed chiropractor who is on the TDI-WC approved doctor's list and 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 physical therapy 3 x week x 4 weeks (12 sessions) is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Pre-authorization Request – 09/20/07, 09/28/07
- Letter of Determination from – 09/27/07, 10/09/07
- Chiropractic/Orthopedic/Neurological Examination – 04/25/07
- Office visit notes – 08/20/07

- Report of x-ray of the sacrum/coccyx – 05/07/07
- Report of x-ray of the lumbar spine and pelvis – 05/01/07
- Electrodiagnostic interpretation – 05/08/07
- Electrodiagnostic results – 05/08/07
- Functional Abilities Evaluation – 05/08/07
- Initial Consultation by Dr. – 05/16/07
- Office visit notes by Dr. – 04/25/07 to 08/28/07
- PEER Review Consultation by Dr. – 08/08/07
- Initial Consultation by Dr. – 05/16/07
- Office visit notes by Dr. – 06/14/07 to 07/12/07
- Pre-Authorization Intake Form – no date
- Notice of Disputed Issue(s) and Refusal to Pay Benefits – 08/13/07
- Pre-authorization Request – 07/17/07, 08/01/07, 09/20/07
- Medical Record Review by Dr. – 09/09/07
- Office visit notes by Dr. 05/16/07 to 07/14/07
- Medical record review by Dr– 05/18/07
- Copy of Occupation Medicine Practice Guidelines provided by
- **Note:** Services provided a copy of the ODG guidelines for Physical Therapy.
- Information for requesting a review by an IRO – 10/10/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was involved in a head on collision with another vehicle while driving a truck. This resulted in a fulcrum point injury to his low back and pelvis. The patient has been treated with medication, chiropractic care and physical therapy.

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

The medical record documentation indicates that this patient has received at least 8 treatments of neuromuscular re-education since his injury. He has received at least 8 treatments of electric muscle stimulation since his injury. He has had a least 24 visits of chiropractic manipulative therapy since his injury. The medical record documentation does not indicate that the patient had therapeutic activities/rehabilitation training since his injury. It is now over 10 months since his injury. He has received sufficient and adequate physical therapy and chiropractic manipulative therapy to date. However, there has not been an aggressive strengthening/rehabilitation program to appropriately address the weaknesses that were documented on his FCE.

National treatment guidelines including the ODG's do allow for active strengthening/rehabilitation training for injuries of this nature when appropriate documentation is present (i.e. FCE). The injured employee has been able to return to work and has been utilizing a home exercise program. It has been several months

since his last FCE and it is possible he has been able to regain his strength and improve upon the deficiencies that were present on the FCE on May 8, 2007. This could have possibly been accomplished via utilization of an aggressive home exercise program, completing as many of his normal job duties as he could accomplish and in general by increasing his normal activities of daily living.

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)

