

MEDICAL REVIEW OF TEXAS

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DATE OF REVIEW: OCTOBER 9, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 Sessions of Physical Therapy

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

MD, Board Certified in Family Practice

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

- * denial letters [7/12/07, 8/14/07]
- * Dr. progress notes [
- * Dr. operative report [9/5/07]
- * Hospitalization [2/9/07 – 2/12/07]
- * Dr. notes [10/16/06, 4/24/07, 6/27/07, 7/31/07, 8/2/07]
- * Dr. progress notes [9/12/06, 8/11/05, 3/6/07]
- * CT lumbar spine [7/19/05]
- * Dr. note [4/19/07]
- * NCS/EMG done 10/11/06, 8/8/03

- * MRI C-spine [3/14/00]
- * C-spine/T-spine [2/18/06]
- * MRI L-S spine [5/25/05]
- * C-spine and T-spine x-rays [2/25/00]
- * C-spine report [9/26/06]
- * ER notes from Medical Center [9/6/06]
- * Operative note [1/3/05]
- * ESI on 5/18/05
- * Dr. note [11/11/06]

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient sustained injuries in an accident. He was treated conservatively including rest, medication, physical therapy and ESI. He also had extensive chiropractic care. He underwent multiple surgeries with limited improvement. Physical therapy notes were not submitted.

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

NO SUBMITTED RECORDS SHOWED SIGNIFICANT IMPROVEMENT OR JUSTIFICATION FOR FURTHER SUPERVISED PHYSICAL THERAPY. ALTHOUGH SOME GUIDELINES RECOMMEND MORE PHYSICAL THERAPY SESSIONS, MOST STATE THE PATIENT HAS TO BE SHOWING CONSIDERABLE IMPROVEMENT IN SYMPTOMS. ALSO, PATIENT HAS TO SHOW PROGRESS IN RETURNING TO HIS JOB. NEITHER OF THESE RECOMMENDATIONS WERE DOCUMENTED. THEREFORE, THE PRIOR DENIAL IS UPHELD.

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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 [NOT PROVIDED]**
- 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)**