

Notice of Independent Review Decision

DATE OF REVIEW: 04/18/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Aquatic therapy at three (3) times a week for four (4) weeks for a total of twelve (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 with an unrestricted license to practice in the state of Texas. The physician is in active practice 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 aquatic therapy at three (3) times a week for four (4) weeks for a total of twelve (12) sessions is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice of Assignment of Independent Review Organization – 04/08/08

- Letter to IRO regarding disagreement of carrier's denial of requested aquatic therapy from Dr. – 04/09/08
- Letter of appeal for requested aquatic sessions from Dr. – 03/31/08
- Operative note – 03/20/08
- History and Physical by Dr. – 02/06/08
- Preauthorization request – 03/31/08
- Decision letter from The Company – 03/26/08, 04/04/08
- Worker's Compensation Initial Evaluation Report – 12/26/07
- Work Comp Interim Report – 03/26/08
- Report of MRI of the right knee – 01/18/08
- Report of MRI of the lumbar spine – 01/18/08
- Letter to designated doctor regarding patient's progress from Dr. – 02/12/08
- EES-14 – 02/04/08
- Return to Work/Extent of Injury Designated Doctor Evaluation – 02/14/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he fell. This resulted in injury to his right knee and lower back. An MRI of the right knee and the lumbar spine revealed a medial meniscus tear involving the posterior one-third of the medical meniscus and disc protrusion at L5-S1 with some foraminal narrowing. The patient has been treated with chiropractic treatments as well as surgery to the right knee.

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

This patient does need some type of post-surgical rehabilitation. The treating doctor indicated in his evaluation report that the patient was walking with an altered gait and limp and was having balance difficulties. The ODG's physical therapy guidelines allow for 12 physical therapy visits for a post surgical (meniscectomy). Under normal conditions a land-based exercise program may be superior. However the ODG's do not specifically require a land-based exercise program post-surgically. Due to the significance of this patient's problems (both subjective symptoms and objective findings) as clinically documented by the treating doctor, aquatic therapy would be more appropriate for this specific case at this time. If this patient was forced into land-based therapy before he is ready, not only would he not received benefit from the land-based therapy, there is a high probability that he would further injure himself.

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)**

