

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Non-network (WC)

12/31/2008

DATE OF REVIEW: 12/31/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

8 visits physical therapy for the lumbar spine

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

Texas State Licensed Doctor of Chiropractic

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

1. Assignment to 12/15/2008
2. notice of assignment of IRO 12/15/2008
3. Confirmation of Receipt of a Request for a Review by an IRO
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 12/11/2008
6. , LC letter 12/18/2008
7. reconsideration denial letter 12/03/2008
8. fax cover sheet to for preauthorization request 11/25/2008
9. denial letter 11/21/2008
10. fax cover sheet to for preauthorization request 11/18/2008
11. preauthorization request 11/18/2008
12. re-evaluation 09/03/2008
13. notice of disputed issues and refusal to pay benefits 08/1/2007
14. notice of disputed issues and refusal to pay benefits 05/20/2007
15. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This xx-year-old adult male was injured on the job on xx/xx/xx. The symptoms are that he has low back pain radiating into the right leg. The treating doctor says that he has provided 15-20 treatments already.

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

The recommended physical therapy treatments are outside the ODG Guidelines. Per the ODG guidelines there is no indication that the requested treatments are going to promote any further resolution of the problem or any healing.

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)