

MEDICAL REVIEW OF TEXAS

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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 5, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy Cervical/Left Shoulder
[97002, 97010, 97012, 97014/G0283, 97035, 97110, 97140]

**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)
- X 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

- * Letter dated 1/18/08 from attorney
- * Dr. 's denial letter (12/18/07)
- * Dr. 's letter upholding denial (1/11/08)
- * Medical records from Dr. from 1/7/08, 12/12/07, 12/7/07, 12/5/07 and 1/17/08

- * ODG Guidelines were included
- * Note from physical therapist dated 9/12/07
- * Progress note on 9/12/07
- * Dr. 's note from 12/7/07
- * A report from MRI of the C-spine from 11/19/07
- * TWCC-73 from 12/18/07

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient sustained an injury. He had suboptimal response to conservative treatment and physical therapy actually worsened his symptoms. He had an ESI and trigger point injections with excellent but temporary relief. Request for physical therapy was denied.

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

THE LATEST PLAN SUBMITTED IS TO REPEAT AN ESI FOLLOWED BY ANOTHER ATTEMPT AT PHYSICAL THERAPY. CONSIDERING THE PATIENT'S SIGNIFICANT AND FAVORABLE RESPONSE TO HIS FIRST ESI, IT IS CERTAINLY REASONABLE TO REPEAT THE ESI WITH A BRIEF TRIAL OF PHYSICAL THERAPY TO ATTEMPT TO ACHIEVE A MORE SUSTAINED OR PERMANENT RESPONSE. IN FOUR SESSIONS, THE PATIENT CAN RECEIVE ADEQUATE TREATMENT WITH A THERAPIST AND VARIOUS MODALITIES AND TRANSITION TO A HOME BASED EXERCISE REGIMEN. THEREFORE, FOUR SESSIONS OF PHYSICAL THERAPY ARE AUTHORIZED SO THE PRIOR DETERMINATION IS PARTIALLY OVERTURNED.

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)**