



# Lumetra

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 01-24 -08

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical Therapy (4 units) for 10 sessions

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

Certified by the National Board of Chiropractic Examiners

### **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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturn
		Prospective	722.11 840.9 842.0 847.2		Upheld

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Notice of Utilization Review Findings 12-27-07 and 01-09-08  
Pre-authorization Request 12-18-07, 01-03-07  
MRI T-Spine 12-17-07  
Initial/Evaluation Report 12-06-07  
Employee Report of Injury xx/xx/xx  
Progress notes 12-07-07, 12-10-07, 12-19-07, 01-03-08  
Official Disability Guidelines (ODG): Chiropractic Guidelines

## **PATIENT CLINICAL HISTORY:**

According to the information received, this xx-year-old claimant's work related injury occurred on xx/xx/xx when the claimant fell over a roll of carpet which resulted in injuries to the wrist, shoulder, mid and lower back regions. The claimant received six chiropractic spinal manipulation and passive physiotherapy modality treatments. MRI of 12-17-07 showed no evidence of acute thoracic spine injury and mild disc degeneration in the lower thoracic spine. The practitioner's request for 10 sessions of physical therapy consisting of therapeutic exercise and neuromuscular re-education was not approved.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The Reviewer determined that the documentation provided does not support the requirement for the requested physical therapy procedures.

The MRI dated 12-17-07 demonstrated no evidence of acute injury to the thoracic spine. The provider submitted a report dated 12-06-07 documenting an initial evaluation. The diagnosed condition appears to involve soft tissue strain/sprain type injuries. There are no baseline measurements provided to the claimant after the initial trial of treatment. ODG recommends objective evidence of functional improvement with the course of treatment provided to support further trial. In the opinion of the Reviewer, the physical therapy sessions requested are not medically necessary for this claimant.

**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)