



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

Workers' Compensation Health Care Non-network (WC)

Original decision date: 01/10/2008

Amended decision date: 01/15/2008

DATE OF REVIEW: 01/10/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3 times a week for 3 weeks

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

Texas State Licensed MD Board Certified Orthopaedic Surgeon

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. Texas DPI Assignment to 1/2/08
2. Notification to URA of Assignment of IRO 1/2/08
3. Confirmation of Receipt of Request for Review by an IRO 12/27/07
4. Section I-VIII undated
5. Email list of additional CPT codes 1/2/08
6. Request form request for a review by IRO 12/21/07
7. Progress note 01/08/08
8. Progress note 12/18/07
9. PA's Appeal review report 12/7/07
10. Notification letter to pt of PA's Appeal review report 12/7/07
11. Fax request of appeal denial 12/7/07
12. Progress note 11/27/07
13. PA's Appeal review report 11/20/07



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14. Notification letter to pt of PA's appeal review report 11/20/07
15. Fax request for appeal of denial 11/15/07
16. PA's Initial review report 11/7/07
17. Notification letter to pt of PA's Initial review report 11/7/07
18. Fax request for preauthorization physical therapy 3xwe X 3 wks
19. Patient eval 11/1/07
20. Progress note 10/31/07
21. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Patient was involved in a repetitive lifting type injury on xx/xx/xx. For the subsequent ten months, the patient has received non-operative management. This has included chiropractic treatment, physical therapy, and epidural steroid injections. An MRI has demonstrated changes at the L5-S1 level consistent with an annular tear.

More recently, another request has been made for an exercise program combined with electrical stimulation and ultrasound. This has previously been denied.

This man has obtained the McKenzie program and is doing that independently at home.

The patient has been assessed and found not to be a candidate for surgery. The patient's physical examination has not shown any neurologic deficit.

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

In my opinion, the previous review outcome should be upheld. Further physical therapy is unreasonable and unnecessary, it should be denied.

I refer to the ODG Guidelines and peer reviewed journals literature including that of Reitman and Esses. The mainstay of physical therapy is an independently performed exercise program. Although initially, it may be beneficial to add some modalities. Modalities such as electrical stimulation and ultrasound are not to be used long-term.

This patient has had ample opportunity to learn an exercise program to be done independently. Further passive modalities is unnecessary, the patient should do a McKenzie program independently. In my opinion, the service in dispute should be denied.

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



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- 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)