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Notice of Independent Review Decision

MARCH 5, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

OT/PT Unlisted Therapeutic Procedure

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

D.O. Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- X 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

Table of Disputed Services

Medical Determination –; 1/22/08, 2/8/08

MRI of the Brain with and without contrast Report– 10/24/07

CT of the Head without contrast – 10/17/07

Neurological Evaluation – M.D. 1/3/08

Medical Records – D.O. 10/24/07 – 2/5/08

PATIENT CLINICAL HISTORY: SUMMARY OF EVENTS:

This case involves a xx year old male who reported a work related injury in xx/xx. The patient works for xx and while at work he was hit on the left side of the head with a pole. He did not lose consciousness. The CT scan and MRI were negative. He was diagnosed with contusion and mild concussion. He was treated with 6 visits of physical therapy. Neurological evaluation in January 2008 was unremarkable. The patient has returned to work without restrictions. More physical therapy was requested and denied.

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

I agree with the benefit company's decision to deny the requested physical therapy. The patient is now four and a half months post injury and he has already been treated with 6 sessions of physical therapy. Neurological workup and evaluation has been unremarkable. He has returned to work at full duty without restrictions. According to the insurance documentation, the patient has already been rendered at maximum medical improvement. The need for continued formal therapy services is not documented anywhere in the notes. His response to the physical therapy that he had is not documented in the records. Further physical therapy does not appear to be medically necessary.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

X 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)