

Envoy Medical Systems, L.P.
1726 Cricket Hollow Dr.
Austin, TX 78758

PH: (512) 248-9020
FAX: (512) 491-5145
IRO Certificate

Notice of Independent Review Decision

DATE OF REVIEW: 8/7/09

IRO CASE #:

Description of the Service or Services In Dispute
PT 3x 4 lumbar

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

Physician Board certified in Neurological Surgery

REVIEW OUTCOME

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

Upheld	(Agree)
X Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

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

Adverse determination letters, 6/18/09, 7/1/09
Letter, 7/28/09, notes 7/22/09, 6/10/09 Dr.
Lumbar MRI report, 6/8/09
Healthcare Notes 5-7/ 2009
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured in xxxx, causing significant lumbar spine change, with one report indicating fractured vertebra. While having persistent pain secondary to that injury, the patient was injured again on xx/xx/xx when he twisted his back while lifting lumber. He developed mid-back pain at that time, along with an exaggeration of his low back pain. There was radiation of the pain into the left lower extremity. X-rays of the chest and thoracic spine and these x-rays were thought normal, showing no evidence of fresh injury. A xx/xx/xx lumbar MRI showed multiple levels of lumbar spine change which were compatible with his persistent low back pain. This "persistent" low back pain was present on 7/28/09. Mid-back pain also persisted, and physical therapy was recommended.

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

I disagree with the denial of the requested physical therapy. Therapy might be beneficial for the patient's new injury in the thoracic spine, and also for the exacerbation of low

back discomfort by the recent injury, improving the patient's total discomfort picture. In the physical therapy section of the ODG guidelines, it states that studies suggest that the use of aggressive physical therapy early on may be beneficial in reducing the discomfort.

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 KNOWLEDGBASE
- 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)