



Notice of Independent Review Decision

DATE OF REVIEW: 6/30/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for 12 sessions of physical rehabilitation.

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

A Texas licensed Occupational Medicine physician.

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.

The previously denied request for 12 sessions of physical rehabilitation

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Texas Department of Insurance Sheet dated 6/19/09.
- Notice to CompPartners, Inc. of Case Assignment Sheet dated 6/19/09.

- Request for a Review by an Independent Review Organization Form dated 6/16/09.
- Fax Cover Sheet/Authorization Request dated 6/22/09, 6/19/09, 6/16/09, 5/11/09, 4/6/09, 2/24/09, 2/6/09, 1/5/09.
- Notice of Assignment of Independent Review Organization Sheet dated 6/19/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization Form dated 6/18/09.
- Follow-Up/Letter dated 6/19/09.
- Notice of Reconsideration Summary dated 6/5/09, 2/27/09.
- Demographics Report dated 6/5/09, 5/13/09, 4/8/09, 2/27/09, 2/10/09.
- Request for Preauthorization Sheet dated 6/2/09, 5/11/09, 4/6/09, 2/24/09, 2/6/09, 1/5/09.
- Request for Reconsideration Summary dated 6/1/09, 2/23/09.
- Notice of Denial of Pre-Authorization Report dated 5/13/09, 2/11/09.
- Notice of Pre-Authorization Report dated 4/9/09, 1/7/09.
- Physical Therapy Progress Note dated 5/7/09, 4/6/09, 2/6/09.
- Physical therapy Evaluation Report dated 1/5/09.
- Initial Consultation Report dated 11/12/08.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Struck by a golf cart and pinned between two vehicles.

Diagnosis: Cervical and lumbar radiculitis and Temporomandibular joint (TMJ) contusion.

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

The claimant is a male who was struck by a golf cart and pinned between two vehicles on xx/xx/xx. The claimant was evaluated by Dr. on 11/12/08 and was diagnosed with cervical and lumbar radiculitis and a contusion of the TMJ. He was given medications and physical therapy (PT) was ordered for 12 visits. PT began on 01/05/09 for his neck and low back. Additional PT for 12 more visits was recommended on 02/06/09. The PT progress note that day stated he was improving with less pain and better ROM of his cervical spine but he still had significant LBP. The additional PT was denied. A request for reconsideration was dated 02/23/09. He had improved but had not plateaued per Dr. who stated he still had functional deficits. On 03/02/09, a reconsideration was sent for peer review. On 04/06/09, additional PT was ordered. The PT note stated he had 7/10 back pain with mild guarding on squatting. He had reduced range of motion (ROM) but it had improved and his strength was increased. Additional therapy was recommended. Six additional visits were certified on 04/10/09. As of 05/07/09, he reported improved activities daily living (ADL) and still had mild

guarding of the cervical region with tenderness. Additional PT was recommended on 05/11/09 but denied on 05/13/09. On 06/01/09, a reconsideration was presented but the denial was upheld. On 06/16/09, an IRO review was requested. On 06/19/09m, Dr. stated he had improved with therapy and he had not plateaued. He had “functional deficits” per Dr. but they were not described. He was continuing to improve but again the improvement was not described. Dr. did not present a physical examination demonstrating specific deficits and his letters dated 02/23/09 and 06/01/09 requesting reconsideration were identical and did not describe any improvement over time with PT. The history and documentation do not clearly and objectively support the request for continued PT at this time for this claimant who has chronic and persistent complaints of pain. He has exhausted the usual number of PT sessions that may be recommended for soft tissue injuries to the neck and back. No physical examination by Dr. has been presented for review in support of this request. Official Disability Guidelines (ODG), Treatment Index, 7th Edition (Web), 2009, Lumbar/cervical sprain (847): recommends up to “10 visits over 8 weeks” with concomitant training in and progression to HEP. On going PT for chronic complaints is not supported by ODG Guidelines. The medical necessity of continued PT and documentation that the claimant is an outlier from the usual evidence-based references, has not been established. Continued PT is not recommended for treatment of chronic pain complaints.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 7th Edition (Web), 2009, Lumbar/cervical sprain (847): recommends up to “10 visits over 8 weeks” with concomitant training in and progression to HEP.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).