

Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: JUNE 29, 2009

IRO CASE #: 20525

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed PT (97530) 3X4 for Thoracic spine

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
847.1	97530		Prop	12			xx-xx-xx		upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-17 pages

Respondent records- a total of 44 pages of records received to include but not limited to:
TDI letter 6.8.09; letters 5.18.09-6.1.09; notes, Dr. 3.26.09-5.5.09; The 5.4.09; Notice of Disputed Issues letter 5.18.09; HCFA 5.7.09; note, Dr. 5.7.09; EOR 5.7.09

Requestor records- a total of 6 pages of records received to include but not limited to:

PHMO notice of IRO; notes, Dr. 3.26.09-4.30.09; MRI T-spine 4.30.09

PATIENT CLINICAL HISTORY [SUMMARY]:

It is noted that this is an individual who was injured on xx-xx-xx. The injured employee underwent several spine surgeries that included fusion with instrumentation dating back several years (2007). Lower extremity weakness was noted on physical examination and well as a decreased ankle jerk.

There is a May 4, 2009 initial physical therapy evaluation completed by, PT. who noted low and mid back pain. This evaluation noted a home based program but did not discuss past physical therapy endeavors. There is a document that indicates that the compensable injury is limited to the lumbar spine injury and does not include a thoracic spine injury.

MRI of the thoracic spine noted no evidence of acute or chronic abnormalities. The April 30, 2009 progress notes from Dr. indicate that the complaints are to the thoracic spine. There was a determination that there is no surgical lesion in the thoracic spine. Ms. was referred to Dr. The operative note was reviewed.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

This therapy is not directed to the sequale of the compensable event. Further, there has been a great deal of post-operative physical therapy and the home based protocols would be applicable. Lastly, there are no finings reported on physical examination that would support a physical therapy protocol for the thoracic spine and the parameters noted in the Division mandated Official Disability Guidelines are not met.

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

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES