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IRO Certificate #

**DATE OF REVIEW: 5/4/09**

**IRO CASE #:**

Description of the Service or Services In Dispute  
Physical therapy 3 x wk x 4 wks

**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)
Overtured	(Disagree)
<b>X Partially Overtured</b>	(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, 4/6/09, 4/21/09  
PT notes October 2008 – March 2009  
Thoracic MRI report 12/5/08  
Report 3/5/09, Dr.  
ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a male who slipped and fell leaving his vehicle in xx/xxxx, and developed mid-back pain. He sought treatment from a chiropractor and was given nine sessions of physical therapy. A 12/5/08 thoracic MRI showed multiple levels of disk bulging and spondylosis, with significant bulging especially at T 9-10. there was no evidence of spinal cord or nerve root compression. On 3/5/09 it was determined that the patient had not reached MMI, and more physical therapy was recommended.

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

I disagree in part and disagree in part with the denial of the requested physical therapy. Further instructions regarding a home exercise program and stretching, along with neuromuscular re education, is medically reasonable and necessary. This, however, could be accomplished with only one week of physical therapy. I disagree with the denial of one week of physical therapy, and agree with the denial of more than one week of physical therapy.

**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
  - 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)