ZRC MEDICAL RESOLUTIONS INC

REVIEWER'S REPORT

DATE OF REVIEW: 11/03/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Eighteen sessions of physical therapy

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
D.C., practicing in the State of Texas for approximately twenty years, Designated Doctor for Texas Workers' Compensation Commission and also a member of the Medical Quality Review Panel, with Advanced Certification in Peer Review, Manipulation Under Anesthesia, and Sports Medicine with approximately thirty years in clinical practice

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

__X __Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:
I reviewed approximately 92 pages which included the following:

1. 22 pages from the Texas Department of Insurance
2. Three pages from Spine, evaluation dated 10/08/09
3. Two pages from DWC preauthorization request, dated 09/11/09
4. Two pages from Spine, a request for reconsideration, 09/03/09
5. Six pages of a preauthorization request from Spine, 09/03/09
6. One page from M.D., 08/03/09
7. Two pages from M.D., a new patient report, 07/13/09
8. Daily notes from Spine of the following dates: 08/13/09, 10/08/09, 09/01/09, 07/28/09, 06/22/09, 05/21/09, 05/20/09, 04/13/09, 04/02/09, 03/30/09, 03/27/09, 03/23/09, 03/19/09, 03/16/09, and 03/12/09
9. DWC-73 reports dated 07/28/09, 09/01/09, 04/13/09, 05/20/09, 02/03/09, 03/03/09

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All of the above mentioned reports were received in duplicate, once from the requestor and once from the Utilization Review agent. There are also two documents from Utilization Review document which were not in the Requestor's packet. One was four pages of a Spine IRO request dated 10/14/09 and a two-page document of a preauthorization request dated 08/14/09.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
The patient was working when he had an injury. He was stocking three 40-pound boxes on a shelf above his head when he began to fall. He reached for them and felt pain in his neck and shoulders as he went to catch them. The date of injury was xx/xx/xx.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
Patients in the State of Texas are entitled future care when medically necessary. However, it appears that this injury was from 2001. It is approximately xxxx years post injury, and the doctor is now requesting eighteen sessions of physical therapy. The patient has been assigned an MMI and an impairment rating date, which was given on one report. However, no DWC-69 was included in either packet. However, it was noted that according to the Spine daily notes that the patient presented initially with this episode with a level 6/10 pain. After approximately five months of therapy over a period of fifteen sessions, the pain was reduced only by one point to 5/10. It does not appear that eighteen more sessions of physical therapy will greatly reduce the patient's pain if it only went down one point over a period of fifteen sessions in several months. Therefore, I must agree with the preauthorization physician that at this time the care is not medically necessary.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:
(Check any of the following that were used in the course of your review.)

__X __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 judgment, 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 national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)

DISCLAIMER/CONFLICT OF INTEREST:
The opinions rendered in this case are the opinions of the evaluator. This medical evaluation has been conducted on the basis of the documentation provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports, or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

I certify that I have no past or present relationship with the patient and no significant past or present relationship with the Attending Physician. I further certify that there is no professional, familial, financial or other affiliation, relationship or interest with the developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the patient whose treatment is the subject of this review. Any affiliation that I may have with this insurance carrier, or as a participating provider in this insurance carrier's network, at no time constitutes more than 10% of my gross annual income.

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