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Notice of Independent Review Decision

DATE OF REVIEW: 11/16/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service under dispute includes 8 visits of physical therapy to the lumbar spine.

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

The reviewer is a Doctor of Chiropractic. The reviewer has been practicing for greater than 15 years and performs this type of service in an outpatient setting.

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)

The reviewer AGREES WITH the previous adverse determination regarding 8 visits of physical therapy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: DC.

10/7/09 denial letter, 9/15/09 denial letter, 10/1/09 letter by Dr , 9/29/09 addendum report, 7/7/09 to 9/4/09 reports by Dr. 8/7/09 PRS, meier and reports.

Dr. : 11/18/08 lumbar MRI report, 11/12/08 to 4/14/09 reports by DO, 6/29/09 patient info form, PLN 11 form 12/17/08,11/12/08 med history report, objective

reports to 7/7/09 to 9/3/09 (PRS, VM,etc),notes by Dr. from 7/7/09 to 10/01/09 and SOAP notes 6/29/09 to 10/16/09 by Dr.

We did receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker was injured on or about xx/xx/xx while working. The injury occurred when he slipped and fell while he was working with a wrench. He was treated at the local ER. The MRI indicates a mild to moderate disc bulge at L5/S1 contacting the S1 nerve root. He was treated conservatively by Dr. He continues to be treated conservatively by Dr. Dr. 's treatments have consisted of physical medicine over an approximately 3 month period.

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

The records indicate that active therapeutics began on 7/14/09 when the notes indicate " the treatment received consists of therapeutic exercise of one unit of time to the lower body." This treatment continued on 7/16, 7/18, 7/20, 7/22, 7/23, 7/24, 7/29 (began neuromuscular re-education as well), 7/30,8/3, 8/5,8/10, 8/12, 8/14, 8/19, 8/21, 8/25, 8/27, 9/1, 9/3, 9/8, 9/10 and 10/16. This treatment plan represents approximately 38 hours of rehabilitation to this patient for his injuries.

The ODG does recommend PT for the current injuries. Lumbar sprains and strains (ICD9 847.2):10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846): Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5): 9 visits over 8 weeks

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8): Medical treatment: 10 visits over 8 weeks

Per the ODG guides, this patient has exceeded the number of treatments recommended. Dr. states in his documentation that the patient is able to return to light duty work. However, he has not been returned at this point.

The notes provided by Dr. do not indicate in any way what types of rehabilitative treatments were provided. They simply indicate that neuromuscular reeducation and therapeutic exercises have been provided.

The reviewer indicates that the records provided do not indicate that the requested services are medically necessary because they do not show documented improvement in repetitions, sets, weights, bands or any other measurable means. The patient has improved in objective measurements such as the Oswestry, etc. The reviewer notes that this indicates that treatment is

working but the type of treatment that is helping this patient cannot be determined without the requested rehabilitation notes.

A 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)