

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 09/23/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3x Wk x 4Wks/Neck-97110-97140-G0283

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

The TMF physician reviewer is a licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the Physical Therapy 3x Wk x 4Wks/Neck-97110-97140-G0283 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO
- Notification of Determination – 07/02/09, 07/29/09

- Pre-Authorization Request – 06/30/09, 09/10/09
- Initial Evaluation – 06/25/09
- Request for IRO for Physical Therapy – 09/10/09
- Rx for pre-surgical evaluation from Dr. – 08/17/09
- New patient surgical consultation – 08/11/09
- MRI scan review by Dr. – 08/10/09
- Reconsideration for physical therapy by Dr. – 07/22/09
- Initial evaluation by Dr. – 04/02/09
- Worker’s Compensation progress note by illegible provider – 03/26/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx while working. He was unloading a truck with a dolly when he slipped and fell, twisting as he fell and feeling a pop in his back. The patient has been treated with medications and physical therapy. The patient still complains of continued pain with tingling and numbness noted down the arms and legs. While the surgeon has written a script for pre-surgical evaluation for readiness for surgery, there is no indication that the patient has undergone surgical intervention. The treating chiropractor has recommended that the patient undergo Physical Therapy 3x Wk x 4Wks.

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

The records indicate the patient has failed conservative care. He has received the physical therapy sessions allowed by the ODGs based upon his subjective symptoms, objective findings and diagnosis. Additional physical therapy would exceed the ODG’s recommendations and would not do anything to further enhance his recovery.

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)