



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 09/01/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten Sessions of Passive & Physical Therapy

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

Board Certified in Physical Medicine & Rehabilitation

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.

Ten Sessions of Passive & Physical Therapy - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Doctor's Note, M.D., 12/11/07, 12/20/07
- X-ray of the Thoracic Spine, M.D., 12/13/07
- X-rays of the Lumbar Spine, Dr., 12/13/07
- Initial Evaluation, PT, 12/14/07
- Employee's Request to Change Treating Doctors, Texas Department of Insurance, 12/28/07
- Initial Evaluation, D.C., 01/04/08
- Physical Therapy, Spine & Rehab, 01/04/08, 01/07/08, 01/09/08, 01/11/08, 01/14/08, 01/16/08, 01/18/08, 01/21/08, 01/23/08, 01/28/08, 01/30/08, 02/04/08, 02/11/08, 02/22/08, 02/26/08, 02/28/08, 03/05/08, 03/13/08, 03/18/08, 03/20/08, 03/27/08, 04/01/08, 04/04/08, 04/15/08, 04/23/08, 04/30/08, 05/02/08, 05/05/08, 05/07/08, 05/09/08, 05/12/08, 05/14/08, 05/16/08, 05/19/08, 05/21/08, 05/23/08, 06/02/08, 06/04/08, 06/06/08, 06/24/08, 07/07/08, 07/15/08, 07/30/08, 08/06/08, 08/20/08, 08/27/08, 09/04/08, 09/05/08, 09/08/08, 09/11/08, 09/12/08, 09/16/08, 09/19/08, 09/22/08, 10/22/08, 10/31/08, 12/02/08, 12/24/08, 03/11/09, 06/09/09
- Cervical Spine X-ray, M.D., 01/07/08
- Cervical Spine X-ray Final Report, M.D., 01/22/08
- Lumbar Spine X-ray Final Report, Dr., 01/22/08
- Electrodiagnostic Study of the Lower Extremities, M.D., 01/30/08
- Office Visit, M.D., 03/11/08, 05/20/08
- Functional Capacity Evaluation (FCE), Spine & Rehab, 03/26/08
- Lumbar Spine X-ray, Dr., 05/12/08
- Physical Performance Evaluation (PPE), D.C., 06/04/08
- Office Visit, M.D., 12/05/08
- Pain Management Consultation, M.D., 04/07/09
- Pain Management Follow Up, M.D., 04/29/09
- Denial Letter, Services Corp, 06/10/09, 06/25/09
- Pre-Authorization Request, Spine & Rehab, 06/10/09
- Reconsideration for Physical Therapy, Spine & Rehab, 06/24/09
- IRO Request for Physical Therapy, Spine & Rehab, 07/08/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was involved in a motor vehicle accident on xx/xx/xx which resulted in ongoing low back pain. He has undergone numerous x-rays of the thoracic, cervical and lumbar spines. He had an EMG performed, as well as an FCE and PPE. He attended approximately 60 session of therapy, as well as a couple sessions of pain management. His most recent medications were noted to be Nexium and Advil.

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

No, the requested ten sessions of physical therapy are neither medically reasonable or necessary.

Having reviewed this rather extensive record, the patient sustained a thoracolumbar sprain/strain on xx/xx/xx during the course of his employment. As an MRI scan post injury, as well as EMG, documented no evidence of any acute pathology, and the diagnosis of sprain/strain was accepted and supported. The patient received extensive physical therapy treatment through the course of this. Further treatment is now being recommended. This would not be reasonable as this sprain/strain, which was clearly present, would be expected to heal within eight to twelve weeks by normal medical expectations. Indeed, at this point he has had considerably more therapy than the ODG would have recommended for a strain/sprain. Therefore, further treatment is no longer reasonable and necessary.

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)**