



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 09/14/09

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 Sessions of Physical Therapy

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

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.

12 Sessions of Physical Therapy - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Physical Examination, , 05/18/09, 07/14/09, 08/05/09
- Muscle Testing & Range of Motion, , 07/02/09
- Denial Letter, , 07/21/09, 08/13/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained an injury to his midback from driving a forklift over unlevel ground containing potholes over time. The patient treated with for chiropractic treatment, as well as undergoing muscle testing and range of motion diagnostic testing. He was not reported to be on any medications.

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

The requested 12 sessions of physical therapy are not medically reasonable or necessary. In accordance with ODG Guidelines and based on the nature of this patient's injury, which does not appear to be anything more involved than a sprain/strain type injury, there is no documentation substantiating anything more involved than a sprain injury. Guideline recommendations would be for a trial of six visits over a two week period, with a maximum of eighteen visits over six to eight weeks. The date of injury is now approximately six months old. I do not see any documentation noting functional improvement and the patient has apparently already undergone twelve sessions of physical therapy. Therefore, the request for an additional twelve sessions of physical therapy based upon the ODG Guidelines for treatment of a low back sprain/strain injury is denied.

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)**