



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
1-800-426-1551 | 715-552-0746  
Fax: 715-552-0748  
medworkiro@charterinternet.com  
www.medwork.org



### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION*

**DATE OF REVIEW: 09/02/2009**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Additional physical therapy 3x Wk x 8 Wks

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

Texas State Licensed MD Board Certified Physical Medicine & Rehab physician

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Texas Dept of Insurance Assignment to Medwork 08/14/2009
2. Notice of assignment to URA 08/14/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 08/14/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 08/05/2009
6. letter 07/28/2009, 07/02/2009,
7. ODG guidelines: Low back – lumbar & thoracic (acute & chronic)
8. Medical notes: 07/27/2009, 07/13/2009, 06/29/2009, 06/15/2009, 06/01/2009, 05/15/2009, PT: 05/11/2009, 05/06/2009, 05/04/2009, 05/01/2009, Medical notes: 05/01/2009, PT 04/29/2009, 04/27/2009, 04/24/2009, 04/22/2009, 04/20/2009, 04/17/2009, 04/15/2009, Medical note 04/10/2009, PT eval 04/06/2009, Medical note 03/27/2009, 03/24/2009, physician listing, treatment history

**PATIENT CLINICAL HISTORY:**

The claimant is a female who sustained an industrial lower back injury dated xx/xx/xxxx, when she was bending over a desk to reach for a computer wire when she felt a slight pop in the low back. The claimant has received 10 physical therapy treatment sessions, and the request is for an additional 24 sessions 3 times per week for 8 weeks.



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

The requested additional 24 physical therapy treatment sessions, 3 times per week for 8 weeks, remains non-authorized, as according to the Official Disability Guidelines, a simple low back sprain would require no more than 10 physical therapy treatment sessions. The claimant has already received the 10 physical therapy treatment sessions that would be recommended by Official Disability Guidelines. The claimant does not demonstrate any documented evidence of lumbosacral spine impairment. Additional physical therapy treatments would not be reasonable or medically necessary. The decision is upheld.

### **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 KNOWLEDGBASE
- 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)