



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Non-network (WC)
MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 07/07/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3x/3wk 97110, 97124, 97140, 97116, 97113, G0283, 97035, 97010

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

Texas State Licensed MD Board Certified Occupational Medicine 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 06/17/2010
2. Notice of assignment to URA 06/17/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 06/16/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 06/15/2010
6. Novare letter 06/09/2010, 05/28/2010, AR Claims Management letter 03/18/2010
7. Pre-cert rqst 06/02/2010, note 05/31/2010, pre-cert rqst 05/25/2010, note 05/25/2010, 05/19/2010, TDI form 05/17/2010, note 05/17/2010, 05/14/2010, 04/28/2010, 04/22/2010, 04/16/2010, TDI form 04/16/2010, note 03/26/2010, TDI form 03/26/2010, note 03/24/2010, 03/19/2010, 03/17/2010, 03/16/2010, 03/15/2010, 03/12/2010, 03/11/2010, TDI form 03/11/2010, note 03/09/2010, DWC form 03/09/2010, TDI form 03/09/2010
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This is a man who reported pain in his low back after lifting heavy objects at work. On examination, he was noted to have decreased range of motion with radicular symptoms. The patient was diagnosed with lumbar strain and was treated with chiropractic manipulation, physical therapy and with a home TENS unit. His symptoms were not resolved and eventually he underwent an orthopedic evaluation. On physical examination revealed decreased range of motion of the back with no clear evidence of radiculopathy or any neurological deficit. His repeat X-rays of the lumbar spine were essentially normal. The patient was again considered to have lumbar strain and was prescribed another trial of physical therapy for the relief of the symptoms.



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

As per ODG Guidelines: 10 physical therapy visits over 5 weeks are recommended for sprains and strains of back. Sprain and strains are self-limiting conditions; majority of them are resolved within few weeks with some palliative measures. Four to 6 weeks of PT is recommended in the cases of acute neck and back pain for the relief of symptoms and improving the range of motion. Generally, PT is considered beneficial in the early phase of the sprains and strains. If a patient does not show significant improvement in this phase it is unlikely to be beneficial in the chronic phase. This patient suffers from low back pain due to lumbar sprain. He was noted to have paraspinal muscle tenderness and restriction of range of motion of the back. There was no evidence of any overt radiculopathy on his examination. He has been treated with about 08 weeks of palliative care, including chiropractic care, physical therapy, and a home TENS unit. However, he was unable to obtain any lasting relief in his symptoms. Per the ODG Guidelines, there is no clear rationale for additional physical therapy for this patient at this clinical stage; therefore, the denial 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)