



Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 05/20/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

M.D., licensed in the State of Texas, board certified specialist in Physical Medicine and Rehabilitation for greater than 35 years and regularly treat and prescribe the type of service for which the predetermination has been requested

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

Additional twelve sessions of active physical rehabilitation (97110, 97112, 97140)

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
	97110		Prosp.						Upheld
	97112		Prosp.						Upheld
	97140		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

1. Certification of independence of the reviewer.
2. TDI case assignment.
3. Letters of denial 04/09/10 & 04/26/10, including criteria used in the denial.
4. Pain management evaluations and PT progress notes, and requests for consideration 03/03, 05/07, 04/05, 04/07, 04/21 & 04/22/10.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual is indicated to have been employed and secondary to striking a rough area was bounced and developed pain for which therapy has been provided to the cervical spine and thoracic spine. Medical treatment has been performed at the Pain and Recovery Clinic under the supervision of, M.D. There is no other indication of specific treatment the individual has received in relationship to the xx/xx/xx date of injury.

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ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

The supplied medical information has been reviewed and noted that the preauthorization request for twelve additional physical rehabilitation treatment sessions has been denied based on the ODG criteria that this would represent exceeding the ODG criterion for this diagnosis. It is also noted that the treatment that the patient has received consisting of ten treatment sessions shows no significant objective evidence of improvement with the treatment that has been provided to date. The reports 04/05/10 are compared, noting, if anything, a slight worsening with the treatment she has received to date. The following is noted in the documentation from the treating provider for those two dates as follows:

- Cervical pain has gone from 4/10 to 4-5/10
- Thoracic pain has gone from 4/10 to 4/10
- Cervical range of motion for the two dates that flexion has gone from 40° to 50°
- Cervical extension from 45° to 45°
- Right rotation from 55° to 60°
- Left rotation from 55° to 55°
- Strength is noted in neck flexion to have gone from 3+/5 to 3/5
- Cervical extension strength has gone from 3+/5 to 3/5

Review of the objective medical information indicates no improvement with therapy, and thus the ODG criteria would indicate that additional therapy of the same type would not be medically reasonable and necessary, and the patient after this length of time would be anticipated to be on a home exercise treatment plan.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)