



**Notice of Independent Review Decision**

**IRO REVIEWER REPORT – WC (Non-Network)**

**DATE OF REVIEW:** 02/24/10

**IRO CASE #:**

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

Twelve Sessions of Active Physical Rehabilitation between 12/23/09 and 02/21/10.

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

Board Certified in Physical Medicine and 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.

Twelve Sessions of Active Physical Rehabilitation between 12/23/09 and 02/21/10 –  
UPHELD

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Prescription and Statement of Medical Necessity, M.D., 06/19/09, 11/16/09
- Evaluation, M.D., 10/23/09
- Physical Therapy, 10/26/09, 10/27/09, 10/28/09, 10/30/09, 11/02/09, 11/04/09
- Progress Note, Dr., 10/28/09
- Progress Note, Elisa X. M.D., 11/04/09
- Progress Note, M.D., 11/06/09
- UR Determination, ESIS, 11/06/09
- Initial Consultation, Dr. 11/11/09

- Physical Therapy, Pain and Recovery Clinic, 11/13/09, 11/16/09, 11/19/09, 11/20/09, 11/23/09, 11/25/09, 11/30/09, 12/02/09, 12/07/09, 12/09/09, 12/11/09, 12/14/09, 12/18/09, 12/21/09, 12/22/09, 12/24/09, 12/30/09
- Request for Pre-Authorization, Dr., 11/16/09
- Denial Letter, , 11/19/09, 12/29/09, 01/12/10
- Consultation, Dr., 11/23/09, 12/28/09
- MRI of the Lumbar Spine, M.D., 12/08/09
- Designated Doctor Evaluation (DDE), D.O., 12/17/09
- Re-Evaluation, Dr., 12/22/09
- Concurrent Review Request, Dr., 12/23/09
- Peer Review, M.D., 01/06/10
- Request for Reconsideration, Dr., 01/06/10
- DWC Form 73, Dr., 01/18/10, 02/01/10
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient had injured his lower back on xx/xx/xx. X-rays had been taken which reported no fractures. He was initially treated with Naproxen 500 mg, Skelaxin 800 mg, Vicodin, and Theragesic cream twice daily. He also underwent physical therapy three times per week for one two weeks. He was taken off of Vicodin shortly after and placed on Darvocet N-100. After being treated by Dr., he was placed on Hydrocodone and instructed to discontinue Darvocet. He was continued on Skelaxin and Naprosyn. He underwent four more weeks of physical therapy. At Dr. request, he underwent an MRI of the lumbar spine. He was treated with Hydrocodone 5/500 mg, Motrin 800 mg and Zanaflex 4 mg by Dr..

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

The date of injury is approximately four months in age. The records available for review do not document that there were any definitive consistent neurological deficits on physical examination. A thorough diagnostic assessment was accomplished after the date of injury. Diagnostic studies included lumbar spine x-rays and a lumbar MRI scan. These studies did not reveal any findings worrisome for an acute psychological process. The claimant was placed at a level of maximum medical improvement (MMI) by a Designated Doctor. A designation of maximum medical improvement typically indicates that ongoing medical care would not be expected to further enhance the physical status of an individual. It would appear that the claimant received at least 23 sessions of physical therapy services after the date of injury. Per criteria set forth by Official Disability Guidelines, it would be realistic to expect that an individual should be capable of a proper, non-supervised rehabilitation regimen when an individual has been provided access to the amount of supervised rehabilitation services previously provided to the claimant. Thus, per criteria set forth by Official Disability Guidelines, there would not be a medical necessity for additional treatment in the form of physical therapy services at the present time. As stated above, the above-noted reference would support an expectation that an individual should be capable of a proper non-supervised rehabilitation regimen when one is this far removed from the onset of symptoms and when an individual has

received access to the amount of supervised rehabilitation services as previously provided. Thus, per the records available for review at this time, Official Disability Guidelines would not support the medical necessity for current medical treatment in the form of physical therapy services.

**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)