

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 11/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3xWK x 4Wks 97035, 97014, 97140, 97110 cervical

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

The TMF physician reviewer is a board certified neurosurgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the physical therapy 3xWK x 4Wks 97035, 97014, 97140, 97110 cervical is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 10/20/10

- Letter of determination– 09/03/10, 09/22/10
- Operative report by Dr. – 04/13/10
- Plan of care for physical therapy – 04/26/10, 06/09/10, 07/02/10, 08/20/10
- Physical therapy progress notes – 04/26/10
- History and Physical by Dr. – 04/27/10
- Outpatient daily notes for physical therapy – 04/26/10 to 07/29/10
- Physical therapy interim/discharge report – 05/26/10, 07/02/10
- Office visit notes by Dr. – 06/04/10 to 10/05/10
- Therapy referral form by Dr. – 06/04/10, 08/17/10
- Prescription for physical therapy by Dr. – 07/02/10
- Report of x-rays of the cervical spine – 08/17/10
- Physical therapy upper quarter evaluation – 08/30/10
- Copy ODG Integrated Treatment/Disability Duration Guidelines Neck and Upper Back (Acute & Chronic) – updated 08/05/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he fell from an elevated position resulting in a cervical injury. The patient had surgery to include an anterior cervical discectomy and fusion and has been treated with physical therapy. The treating physician has recommended that the patient have continued physical therapy at 3 times a week for 4 weeks.

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

The medical record either does not satisfactorily document the rationale for additional therapy or is not legible. The one legible document (dated 07/02/10 “physical therapy report”) states that goals were 83% met and indicated pain and weakness but does not state why these conditions could not be managed with home exercise instruction and pain management.

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)