

Envoy Medical Systems, L.P.
1726 Cricket Hollow Dr.
Austin, TX 78758

PH: (512) 248-9020
FAX: (512) 491-5145
IRO Certificate #

Notice of Independent Review Decision

DATE OF REVIEW: 1/14/11

IRO CASE #:

Description of the Service or Services In Dispute
Physical therapy thoracic spine 3 x 4 wks

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

Physician Board Certified in Physical Medicine and Rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

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

Adverse determination letters, 12/27/10, 12/16/10
Request for reconsideration 12/20/10
Physical Assessment Evaluation and Treatment Plan 12/10/10, Dr.
Medical notes 12/9/10, Dr.
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient, who does repetitive work at her job, complained of thoracic pain and given an initial impression of thoracic sprain. She later had complaints of pain in her neck, right shoulder, thoracic spine, right hand, with areas of right upper extremity numbness. In May 2010 the patient completed 12 physical therapy sessions to the cervical spine. She also completed 12 physical therapy treatments to the right shoulder in December 2010.

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

I agree with the decisions to deny of the requested services. It has been a long time since the onset of the symptomatology, and the patient reportedly has had 24 physical therapy treatments to the upper body. This is outside the paradigm of the ODG, and I agree that further physical therapy is not indicated. The patient can be instructed in a home exercise program.

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)