



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org



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

05/10/2011

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 05/10/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

18 additional PT & aquatic therapy (97113, 97140, 97116, 97014, 97035, 97530)

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

Texas State Licensed DO Board Certified Physical Medicine & Rehab 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

PATIENT CLINICAL HISTORY:

The claimant is a female who sustained an industrial lower back injury dated xx/xx/xx. The claimant sustained lower back pain with right L4-L5 distribution of lower extremity radicular pain. The claimant also sustained a left lower extremity injury resulting in a compartment syndrome requiring fasciotomy on July 30, 2010. Because of complications with postoperative wound healing, skin grafting was required in September 2010 with associated left footdrop secondary to muscle and nerve trauma. As of December 2010, the claimant experienced low back pain with radiation of the pain to the right lower extremity while elevating the left lower



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extremity as required for postoperative healing. The claimant was complaining of increased right lower extremity symptoms worse than the postsurgical left lower extremity symptoms. Physical therapy for management of the right lower extremity status post fasciotomy and right footdrop was initiated on January 6, 2011. However, the claimant progress has been limited by low back pain and right lower extremity radicular pain. The claimant has undergone lumbar spine injections and oral steroid management. The physician is requesting 18 additional PT & aquatic therapy (97113, 97140, 97116, 97014, 97035, 97530) for spinal unloading/traction to ease nerve compression and improve mobility.

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

The claimant has received at least 12 sessions of physical therapy treatment for management of the diagnoses of sciatica and of thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD-9 724.3, 724.2), which is permitted 10-12 visits over eight weeks according to the Official Disability Guidelines. Review of the physical therapy plan of care dated February 22, 2011, does not specifically address physical therapy management of post-July 26, 2010, musculoskeletal injury complications management by physical therapy/rehabilitation measures. Although the claimant presents with a complex history and multiple musculoskeletal injuries, based upon Official Disability Guidelines and the review records, the insurer's denial of the requested 18 additional PT & aquatic therapy (97113, 97140, 97116, 97014, 97035, 97530) 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



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- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**