



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)

05/26/2011

DATE OF REVIEW: 05/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

8 (eight) additional sessions of physical therapy for the back

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

1. Texas Dept of Insurance Assignment to Medwork 05/11/2011
2. Notice of assignment to URA 05/11/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 05/11/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 04/20/2011
6. 05/13/2011, 03/23/2011, Preauthorization 03/17/2011, 03/16/2011, 03/07/2011, 03/03/2011, 03/02/2011, 03/01/2011, 02/23/2011, 02/21/2011, Medicals 02/17/2011, 02/15/2011, 01/18/2011, 01/11/2011, 10/04/2010, 09/07/2010, 08/31/2010
7. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:

The claimant is a female who sustained a cervical/thoracic sprain/strain injury dated xx/xx/xx, while performing usual occupational duties. On that date, she sustained a fall on trailer stairs, landing on her back. The claimant received conservative care, including physical therapy treatment, according to the Official Disability Guidelines. Review request is for 8 (eight) additional sessions of physical therapy for the back.



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

Based upon the Official Disability Guidelines, 2011, web-based edition for physical therapy treatment of sprains and strains of unspecified parts of the back, the guidelines limit the treatment to no more than 10 visits over 5 weeks. The claimant is now approximately 9 months post-injury. The diagnostic testing of the claimant does not demonstrate any unusual circumstance or evidence of neurocompression, as the cervical spine diagnostic x-ray series is demonstrating C5-C6 disc space narrowing and the claimant diagnosis is neck pain/degenerative disk disease; therefore, the insurer's decision to deny the requested 8 (eight) additional sessions of physical therapy for the back 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 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)