

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 01/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional physical therapy for the thoracic and lumbar spine, right shoulder, right wrist/hand and right knee, 3 times a week for 2 weeks as an outpatient.

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

The TMF physician reviewer is board certified in physical medicine and rehabilitation 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 additional physical therapy for the thoracic and lumbar spine, right shoulder, right wrist/hand and right knee, 3 times a week for 2 weeks as an outpatient 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 – 01/04/12
- Notice of Denial of Pre-Authorization – 11/30/11
- Services case notes – 12/08/11
- Notice of Reconsideration – 12/28/11
- PT/OT Pre-Authorization Request Form Medical Centers – 11/22/11, 12/21/11
- Office visit notes with orders for continued physical therapy by Dr. – 11/17/11, 12/12/11
- Status Report Follow-up Evaluation by Dr. – 11/22/11, 12/12/11
- Physical Therapy re-evaluation – 11/10/11, 12/14/11
- Physical Therapy Daily Notes – 11/21/11, 12/14/11
- Letter from Dr. – 12/19/11

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on xx/xx/xx that resulted in bilateral lumbar sprain, thoracic sprain/strain, bilateral muscle spasm, left shoulder joint pain, right knee internal derangement, right wrist and carpus enthesopathy. The patient has been treated with physical therapy and there is a request for continued physical therapy at 3 x a week for 2 weeks.

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

This injured worker has been treated with physical therapy and there is a request for an additional 6 sessions at 3 times a week for 2 weeks. The ODG Guidelines accept up to 9 or 10 therapy sessions. Based on the information provided for review, it appears that the patient has matched these. The additional 6 sessions would exceed the ODG Guidelines and the intensity of 3 times a week would also exceed the ODG Guidelines. While the ODG does allow for variance based upon clinical information, the clinical information provided for review does not warrant this variance.

### **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)