

Notice of Independent Review Decision

**DATE OF REVIEW: 03/05/2012**

**IRO CASE #: 39584**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical Therapy 3 x wk x 4 wks 97140, 97035, 97110, G0283

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

**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.

Upon independent review, I find that the previous adverse determination should be upheld: Patient has already exceeded the criteria and there is no medical information or rationale to exceed these criteria provided

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records Received: 15 page fax 2/14/12 IRO request, 28 and 27 page fax 2/15/12 URA response to disputed services including administrative and medical records. Dates of documents range from 01/06/01 to 2/14/12.

# The DYLL REVIEW

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25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-443

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

Patient with DOB 1/11/1969 had an original injury at work 1/6/2001. Had recent cervical spine surgery with fusion at C4/5 and C5/6 in May 2011. Has also had post surgical physical therapy with 26 treatment sessions. Began having discomfort in the thoracic / cervical region and referred for 12 physical therapy sessions. No new injury. No information concerni patient participation in HEP.

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

Post surgical physical therapy ODG criteria indicates 24 treatment sessions. Patient has already exceeded the criteria and there is no medical information or rationale to exceed these criteria provided.

### **ODG Cervical and Thoracic spine**

Displacement of cervical intervertebral disc (ICD9 722.0):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

**Post-surgical treatment (fusion, after graft maturity): 24 visits over 16 weeks**

**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)