

Notice of Independent Review Decision

DATE OF REVIEW: 10/11/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

6 sessions of thoracic physical therapy at 3 times a week for 2 weeks

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 6 sessions of thoracic physical therapy at 3 times a week for 2 weeks are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 09/23/13
- Adverse Determination Letter – 08/07/13, 09/03/13
- One page of an orthopedic exam – 05/13/13
- Request for preauthorization – 08/09/13
- Request for Reconsideration – 08/09/13
- Physical Therapy Evaluation – 08/05/13

- Initial Evaluation Report – 05/09/13, 05/13/13
- Prescription for Physical Therapy – No date
- Report of MRI of the lumbar spine – 09/11/13
- Report of MRI of the thoracic spine – 07/23/13
- Employee Injury and Treatment Form – 05/09/13
- Progress Notes – 05/09/13 to 07/15/13
- Initial Medical Report – 05/22/13
- Subsequent Medical Report – 07/09/13, 08/05/13

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx He complains of tenderness, tightness, and myospasm over the thoracic and lumbar bilateral paraspinal musculature. He has been treated with chiropractic care and physical therapy and there is a request for 6 sessions of thoracic physical therapy at 3 times a week for 2 weeks.

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

According to standards of care including the ODG Treatment Guidelines and North American Spine Society (NASS) practice guidelines, this patient requires further diagnostic modalities instead of further physical therapy at this juncture. He has failed conservative treatments after three months of physical therapy and needs further diagnostic modalities. There is a notation that an MRI of the thoracic spine was performed and was normal. This patient has not undergone a complete diagnostic evaluation.

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)**

North American Spine Society (NASS) Clinical Practice Guidelines