



BHM Healthcare  
Solutions/Medwork  
2525 Ridgmar Boulevard Suite 334  
Fort Worth, Texas 76116  
[ExternalReviews@bhmpc.com](mailto:ExternalReviews@bhmpc.com)  
[Pareviews@bhmpc.com](mailto:Pareviews@bhmpc.com)  
Office 1-888-831-1171  
Facsimile 1-888-818-2425

**DATE OF REVIEW:** 12/18/17

**IRO CASE #:** XXXX

**DESCRIPTION OF THE SERVICE(S) IN DISPUTE:**

Physical Therapy 3x's per week for 90 days

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

Texas State Licensed MD Board Certified in Physical Medicine & Rehabilitation

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> 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.

**PATIENT CLINICAL HISTORY:**

The patient is a XXXX. The patient has a history of a XXXX resulting in traumatic paraplegia. The patient has completed extensive inpatient, outpatient, and home rehabilitation.

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

This patient would be expected to have long ago transitioned to an independent active home rehabilitation program. Any further improvement in function is likely to occur spontaneously with or without specific treatment or other goals.

**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
- ☐ PRESLEY 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)