Parker Healthcare Management Organization, Inc.
3719 N. Beltline Rd Irving, TX 75038
972.906.0603 972.906.0615 (fax)
IRO Cert#

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO- 26 pages

Respondent records- a total of X pages of records received to include but not limited to:
X letter X; Letter from X, PT, DPT dated X; The Rehabilitation Group dated X; Utilization Management Referral X; X records X

Requestor records- a total of 0 pages of records received to include but not limited to:
Notice of IRO assignment request for records X and sent X. No records received

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a request for reconsideration for X Evaluation and Treatment of the X, 8-12 weeks. The claimant is a X-year-old X who was injured on X, in an X. The claimant was diagnosed with X. The claimant was noted to be X with X. A letter of medical necessity dated X, was made available for review. The claimant had undergone multiple X There was development of a X. The claimant has spent several months in inpatient rehabilitation due to significant loss of function in X. There was a significant decline in functional capability and reports of difficulty X. The claimant also reported to have significant X. There was an inability to X was noted which would always require XX XX for XX, X. It is noted that the claimant has been under the care of several physicians to include X since the initial injury and according to medical records provided for review, the claimant has functional capabilities that have not improved in spite of the extensive treatment.

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ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:
This request was previously non-certified by Dr X on, as there had been X in spite of extensive treatment since the date of injury without improvement in functional capabilities to warrant additional requested physical therapy. No additional documentation was provided to support the request. The previous non-certification is supported. According to the guidelines, physical therapy for X in the X phase is recommended up to twelve treatment sessions over twelve weeks and the current request does not specify the number of sessions requested. Also, it is well documented that the claimant has had X since the date of reported injury without documented functional improvements. There is no documentation provided to support the amount of treatment sessions that the claimant has completed to support the medical necessity of additional requested physical therapy sessions. Therefore, the request for an X evaluation and treatment of the X, eight to twelve weeks is not certified as it does not meet the standards for medical necessity.

Official Disability Guidelines Treatment Integrated Treatment/Disability Duration Guidelines X (updated X) Official Disability Guidelines Physical medicine treatment Recommended. Official Disability Guidelines Physical Medicine Guidelines – Allow for fading of treatment

frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. X: X phase: 20-40 visits over 4 weeks X phase: 6-12 visits over 12 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

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

XX 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)