

**An Independent Review Organization**  
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Notice of Independent Review Decision

DATE OF REVIEW:

08/08/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

PT 3 X A WEEK X 4 WEEKS

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

Master's in Physical Therapy and Certified as an Orthopedic Clinical Specialist (OCS) and a Certified Manual Physical Therapist (CMPT).

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Treatment notes Sports and Physical Therapy 06/05/07-07/02/07

Review Determination letters 07/09/07, 07/16/07

07/31/07 letter to, PT, with attached Exhibits 1-6 (including ODG guidelines and physician treatment notes 05/17/07-06/06/07)

Letter 07/09/07

PATIENT CLINICAL HISTORY [SUMMARY]:

Injured employee is a female sustaining a cervical and lumbar strain injury after another coworker fell on her. This employee is suffering from pain/spasms in both the neck and low back area.

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

The decision to uphold the original denial for additional PT benefits is largely based on the lack of objective data as it pertains to functional goals and outcomes during the first 10 visits of therapy. Objective pain function did not objectively change from evaluation to re-evaluation. Pain 5/10 down to 4/10 is not effective enough treatment to warrant continuation. The Visual Analog scale for pain is subjective and there was no connection to any measurable functional goals.

Only minimal objective data was documented regarding range of motion and despite objective changes, no objective functional changes were measured. Sitting, standing, and transfer tolerance/ability were documented subjectively only. No work status was documented or connected with any PT goal/objectives. No physical barriers were identified.

Finally, no objective exercise tolerance was achieved. The injured employee participated in 10 PT sessions all of which consisted of basic exercises. No exercises addressed the employees functional deficits and no consistent progression was made per the PT exercise flow sheet.

If a more comprehensive PT evaluation had been performed with appropriate measurable functional goals/outcomes, along with exercises and treatment parameters to address these goals, an extension would have been necessary.

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
  - APTA GUIDE TO PHYSICAL THERAPY PRACTICE