

**DATE OF REVIEW: 5/29/07****IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Continuing physical therapy, 12 additional visits.

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

This case was reviewed by a board certified physical medicine and rehabilitation specialist on the external review panel who is familiar with the condition and treatment options at issue in this appeal.

**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)

Primary Dx Code	HCP CS	Units	Type Review	DOS	Amt Billed	Date of Injury	Claim #	Uphold / Overturned
847.2	97139		Prospective					Partial Overturn

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for Independent Review by an Independent Review Organization forms – 5/10/07
2. Determination Notices – 4/12/07, 5/7/07
  1. Physical Therapy Prescription – 4/9/07
  2. Records and Correspondence from Clinic – 3/7/07-4/30/07
  3. Records and Correspondence

**PATIENT CLINICAL HISTORY:**

This case concerns a female who sustained a work related injury. Records indicate the patient was involved in a motor vehicle accident and was thrown forward on impact. Records also noted she was treated and released from an emergency room. Diagnoses

have included lumbar sprain, strain, myalgia and myositis. Evaluation and treatment for this injury has included therapeutic exercise, therapeutic activities, electrical stimulation, joint mobilization, home exercise, neuron re-education, ultrasound, taping and massage.

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

This patient was injured during a motor vehicle accident. She experienced symptoms including neck pain, shoulder pain, back pain and hip pain. She was seen by physical medicine and rehabilitation and was noted to have decreased range of motion in the cervical and lumbar spine. She had no radicular signs and no muscle weakness or numbness. Her gait was normal. Records reported that x-rays were normal and she was felt to have cervical and lumbar strain and thoracic myositis/fasciitis. The records do not indicate whether she was evaluated by any other provider besides the emergency room visit since her injury or if she underwent any treatment prior to the recent physical therapy sessions started. Records noted she has physical therapy through 4/9/07 consisting of therapeutic exercise, electrical stimulation, massage, myofascial exercises, and joint mobilization. A physical therapy re-evaluation on 4/9/07 reported her cervical range of motion was improved (but still with 30% loss), her lumbar spine range of motion was normal, and her pain level was 3-6 on a scale of 1-10 in the neck and 2-7 in the back. She was noted to be doing a home exercise and was independent in her home exercise program. The re-evaluation note did not indicate whether any short or long term goals initially set were met. From review of the available data, the patient has progressed with physical therapy although there is no record of the initial evaluation to measure objective improvements. It is not clear if this is the patient's first session of physical therapy since the injury. Although the patient is independent with a home exercise program, 2 more weeks of skilled physical therapy are medically necessary for continued improvement and to prevent decline in functional gains. Therefore, 6 of the requested 12 physical therapy sessions are deemed medically necessary for treatment of this patient's condition at this time.

**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)