

**Notice of Independent Review Decision**

**DATE OF REVIEW:**            04-02-08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical Therapy

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

Certified by the American Board of Orthopaedic Surgery

**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)

Injury Date	Claim Number	Review Type	ICD9/ DSMV	HCPCS /NDC	Service Units	Overturn/ Upheld
		Prospective	723.1	97002	1	Upheld
		Prospective	847.0	97014	12	Upheld
		Prospective	742.2	97035	12	Upheld
		Prospective	847.7	97110	12	Upheld
		Prospective	841.1	97124	12	Upheld
		Prospective		97140	12	Upheld
		Prospective		97530	12	Upheld
		Prospective		97113	12	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

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Notice of Adverse Determination dated, 03-20-08  
Notice of Adverse Determination (reconsideration) dated, 03-20-08  
Physician Determination – Appeal dated, 03-11-08 and 03-17-08  
Preauthorization Request Form dated, 03-10-08, 03-13-08 and 03-19-08  
Therapy Referral (evaluate & treat) dated, 03-04-08  
Physician medical notes, dated 10-25-07, 11-01-07, 12-17-07, 01-08-08,  
03-04-08,  
Physical Therapy Initial evaluation dated, 12-10-07  
Physical Therapy daily progress notes dated, 01-02-08, 01-04-08, 01-07-08,  
01-09-08, 01-11-08, 01-15-08, 01-16-08, 01-17-08, 01-24-08, 01-25-08,  
02-29-08, 03-04-08,  
Electrodiagnostic Evaluation {electromyogram (EMG) / nerve conduction study  
(NCS)} dated, 12-11-07  
MRI lumbar spine dated 12-11-07  
Notice of Disputed Issues dated 12-19-07 and 01-10-08  
Official Disability Guidelines (ODG) Web-Based 13<sup>th</sup> Ed Neck and Upper Back:  
Physical Therapy

**PATIENT CLINICAL HISTORY:**

On 12-11-07, the EMG/NCS study noted a carpal tunnel syndrome and no evidence of cervical radiculopathy either chronic or acute. The lumbar MRI noted advanced arthritic disease and a disc bulge.

The treating physician's initial examination noted that the claimant slipped and fell. Plain films showed degenerative changes. An SI joint injection was performed. At follow-up in December, another injection and physical therapy were prescribed. In January 2008 the problem list included the diagnoses of Sprain of Neck and Sprain of Thoracic Region.

The Reviewer noted twelve sessions of physical therapy. At follow-up with the treating physician on 03-04-08, the claimant was feeling "a little better". Topical non-steroidal medication cream was prescribed and additional physical therapy ordered. According to the records submitted, the claimant has completed 24 sessions of physical therapy and no additional physical therapy was certified.

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

In the opinion of the Reviewer, the findings noted on physical examination and the modest improvement made with the physical therapy already delivered and

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considering the parameters in the ODG, additional physical therapy is not clinically indicated. Therefore, additional physical therapy is not medically necessary for this claimant.

**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)