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Notice of Independent Review Decision

DATE OF REVIEW: 08-20-2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy for right shoulder, neck strain, chest wall contusion
3x4=12 sessions

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

Certified by the National Board of Chiropractic Examiners

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 #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Service Units	Upheld/ Overturned
		Prospective	723	97140 97110 97112 97010 G0283	12	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Pre-Authorization Determination, dated 06-26-08

Preauthorization Review Summary, dated 06-12-08 & 06-30-08
Physician letter (reconsideration appeal), dated 06-13-08
E-mail sent 06-12-08 (denial upheld)
Physician prescription – outpatient physical therapy, dated 06-13-08
Progress report, dated 06-09-08
Physical Therapy Initial Evaluation/Examination, dated 05-09-08
Physical therapy Progress/Treatment notes, dated 05-12-08 to 05-29-08, 06-09-08 to 06-10-08
Official Disability Guidelines (ODG) Neck & Upper Back Physical Therapy Guidelines; ODG Preface Physical Therapy Guidelines

PATIENT CLINICAL HISTORY

This is a patient with work-related motor vehicle accident on xx/xx/xx. The patient received 4 weeks of physical therapy with some good results. However, the patient continues to have pain in the neck, back and chest, which limit her daily function.

The treating physician requested additional physical therapy to help with mobility. The request was denied as not medically necessary per ODG criteria.

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

The Reviewer noted no objective finding documented in the records provided in this case related to the injury on xx/xx/xx which was remarkable in degree or complexity that would support the extension of the requested supervised physical therapy. ODG parameters support physical therapy for 10 sessions over the duration of 8 weeks. The patient has been provided supervised physical therapy for 12 sessions, and the duration has now been about 4 months. The current condition would appear to be compatible with a transition from active in office supervised care to home-based self-directed protocols.

Based on the comprehensive investigation and research into Whiplash Associated Disorders (WAD), the Quebec Task Force found injuries from motor vehicle accidents to be self-limiting with a median recovery time of 31 days. The benefits of early return to usual activities of daily living and normal work activities are emphasized. Most incidents of WAD involve temporary discomfort for days or a few weeks requiring little medical intervention and rarely result in permanent harm (Spine, 1995, April 15; 20: 10S-68S). In this case, there were no objective physical findings documented that placed this patient outside these parameters.

Therefore, in the opinion of the Reviewer, the requested physical therapy sessions are not medically necessary for this patient.

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)**