



Notice of Independent Review Decision

**DATE OF REVIEW:** 1/31/08

**Amended date:** 2/1/08

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for 9 visits of physical therapy.

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

Texas Licensed Orthopedic Surgeon.

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for 9 visits of physical therapy.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 1/23/08.**
- **Request Form dated 12/3/07.**
- **Review Summary dated 1/23/08.**

- Notice to, Inc. of Case Assignment dated 1/24/08.
- Request for Physical Therapy dated 1/14/08.

No guidelines were provided by the URA for this referral.

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xx years

**Gender:** xxxxx

**Date of Injury:** female

**Mechanism of Injury:** Not provided for this review.

**Diagnosis:** Neck strain and myofascial pain.

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

The claimant is a xx-year-old female who sustained a work related injury on xx/xx/xx. The mechanism of injury was not provided for review. On 11/21/07, the claimant had completed 14 sessions of physical therapy (PT) with the diagnoses of neck sprain and contusion of the shoulder and upper arm. Examination showed full range of motion with 5/5 strength and no abnormal examination findings. At that time, she was taking oral non-steroidal anti-inflammatory drugs (NSAID's) and was working modified duty. On 1/8/08, the claimant had no significant improvement in symptoms and was working normal duties. At that time, the diagnoses were head contusion and cervical strain with myofascial pain. DO, (PM&R), spoke with Dr. on 1/23/08. Dr. noted that PT had been recommended by the neurosurgeon. The Official Disability Guidelines (ODG), under cervical spine - procedure summary, states, "Physical therapy is recommended for 10 visits over 6 weeks for cervical strain." The claimant has exceeded the ODG recommendations, having completed 14 PT sessions. She made no significant improvement, but her clinical findings demonstrated normal motor function at 5/5 and full range of motion (cervical). In light of the above, the available clinical information does not support the need for continued additional structured PT. Therefore, this reviewer does not recommend approval of the additional PT, 9 visits.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disabilities Guidelines (ODG) 2007, 2nd Edition.

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).