

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 5/12/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy three times a week for four weeks for the neck and back to include 97110, 97124, 97140, 97530, 97014, 97035, and 97113

QUALIFICATIONS OF THE REVIEWER:

This reviewer attended the University of Pittsburgh School of Medicine after completing his undergraduate degree at the University of Virginia. He completed an internship and residency at Pennsylvania State University. He has been actively practicing since 1990. He is a member of the American Academy of Orthopaedic Surgeons and the American Medical Association.

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)

Physical therapy three times a week for four weeks for the neck and back to include 97110, 97124, 97140, 97530, 97014, 97035, 97113 Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical note dated 4/23/2008
2. Review organization dated 4/23/2008
3. Independent review organization dated 4/21/2008
4. Clinical note dated 4/16/2008
5. Clinical note dated 4/21/2008
6. Case assignment dated 4/24/2008
7. Clinical note dated 4/28/2008
8. Independent review organization dated 4/24/2008
9. Review organization dated 4/23/2008
10. Independent review organization dated 4/21/2008
11. Clinical note dated 4/16/2008
12. Clinical note dated 4/21/2008
13. Physician review recommendation by MD, dated 4/15/2008
14. Physician review recommendation dated 4/18/2008
15. Clinical note dated 4/11/2008
16. Therapy referral dated 4/4/2008
17. Evaluation plan of care dated unknown.
18. Clinical note by MD, dated 4/4/2008
19. Clinical note dated 4/16/2008
20. Therapy referral dated 4/4/2008
21. Evaluation plan of care dated unknown.
22. Clinical note by MD, dated 4/4/2008

Name: Patient_Name

23. Clinical note dated 4/16/2008
24. Therapy referral dated 4/4/2008
25. Evaluation plan of care dated unknown.
26. The Official Disability Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male who was involved in a motor vehicle accident with resultant neck and low back pain without radicular pathology into the extremities. He was diagnosed with cervical and lumbar strains.

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

The clinical information available documents the date of injury as xx/xx/xxxx. Thus this individual would be approximately five weeks from the date of events. The most appropriate diagnosis appears to be that of a soft tissue injury to the neck and back. According to ODG guidelines, individuals can benefit from physical therapy of up to ten visits over several months. In most cases, individuals' symptoms will typically resolve within weeks.

At this point in time, the clinical information and evidence based guidelines would support six to eight sessions of physical therapy over a three to four week period with anticipation of transition to a home exercise program. This would be reasonable and appropriate based on the clinical information provided. The request for therapy three times a week for four week is in excess of the guideline recommendations and thus cannot be approved. Therefore, the previous denial is upheld.

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)