IRO America Inc.

7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Phone: 512-266-5815
Fax: 512-692-2924

DATE OF REVIEW:
JULY 22, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Physical therapy (97110, 95851) on February 2, 6, 7, 8, 2007

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
MD Board-certified Internal Medicine, with a specialty in Physical Medicine and Rehab

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Notification of Case Assignment, Medical Records from Requestor, Respondent, Treating Doctor (s), including:
Dr., March to August 2006
Dr., August 2006 to January 2007
Work hardening notes, August 2006
Physical therapy, January to February 2007
Carrier correspondence

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant was injured in xx/xx/xx when she lifted and threw a bag of linen. MRI of the cervical spine showed two HNPs. She underwent 2-level cervical fusion in April 2006 with marked improvement of the neck and radicular symptoms. However, right shoulder symptoms persisted. In November 2006 she underwent rotator cuff repair by Dr. The claimant had twelve sessions of physical therapy in January and February 2007 with improvement in function and symptoms.

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

A review of the applicable guidelines and peer-reviewed medical literature finds good evidence to support the use of up to 24 sessions of physical therapy over 14 weeks. The therapy provided in this case falls within these recommendations, both in number and in length of treatment. Therefore, the treatment provided is reasonable and necessary to treat the claimant's injury. Thus, the Reviewer disagrees with the determination of the insurance carrier.

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)