

Clear Resolutions Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726

DATE OF REVIEW:
JUNE 2100 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3 x a week for 6 weeks (18 sessions) post-operative physical therapy.

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

Licensed

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Upheld | (Agree) |
| <input checked="" type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> 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

Request IRO form, IRO request and forms, TDI letter 6-14-2007, 13 pages IRO information, Notification of Determination 5-22-2007 and 5-20-2007, Request for IRO letter 6-15-2007 PT, Prescription for PT, Operative report for cervical spine 1-03-2007, Report PT 4-09-2007, Medical report Dr. MD 5-25-2007, Designated Doctor Exam 5-14-2007, PT notes associated dates

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, the Patient was injured when a heavy shelf fell and struck her on the neck. The injured employee underwent a CT scan of the cervical spine. MRI of the cervical spine was performed on xx/xx/xx. On xx/xx/xx, the Patient underwent a spine consult with Dr. On 1/03/2007, cervical fusion of the C5-6 disc was performed. On 4-5-2007, the injured employee started post-op PT. On 5-14-2007, Designated Doctor assessed her at MMI and assigned a 5% WB IR and recommendations were made for post-operative therapy.

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

The injured employee injured the cervical spine and eventually underwent a C5-6 cervical fusion with instrumentation. Post-operative PT was recommended by several physicians and initiated on 4-5-2007. ODG recommends 16+ visits of post-operative therapy. It was noted that the injured employee underwent a C5-6 fusion and post-operative physical therapy. Thus, the Reviewer disagrees with the determination of the insurance carrier and agrees that the requested physical therapy is medically necessary.

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)