

Clear Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW: OCTOBER 10, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Sixteen sessions of physical therapy

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

M.D., Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/29/07, 9/19/07

Notes from URA Doctors

ODG Guidelines

Dr. 7/24/07

Dr. 8/16/07

Physical Therapy Notes, 7/24/07, 7/26/07, 7/27/07, 8/01/07, 8/02/07, 8/08/07, 8/06/07, 8/03/07, 8/16/07, 8/14/07, 8/10/07 8/23/07, 8/24/07, 8/28/07, 8/29/07, 8/30/07, 9/20/07

Exercise Flow Sheet, 7/24/07, 7/26/07, 8/28/07, 9/20/07

Home Program Review, 9/24/07

Prescription for physical therapy, 07/12/07
Prescription for physical therapy, 08/10/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This male claimant was reportedly diagnosed with a cervical strain/ sprain following an injury . The records indicated that the claimant was treated with physical therapy for approximately twelve sessions with noted improvement. Records also indicated that the claimant had undergone a previous two level cervical fusion in 2006. An additional one to two sessions of physical therapy was authorized for transition into a home exercise program. The attending physician has requested additional physical therapy.

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

The claimant is a gentleman who has been receiving therapy for neck and upper back pain. The medical records I have for review which essentially include physical therapy records, and a 08/29/07 peer review of Dr. and a 09/19/07 peer review of Dr.. Dr. felt that further physical therapy was not indicated due to prior therapy with improvement. Dr. noted he spoke with the treating physician who apparently agreed that no further therapy was needed and this person could be capable of a self directed home exercise program.

Based on the medical records that I have for review, it is not clear that further physical therapy would be necessary and therefore I agree with the previous determination of the insurance carrier that no further physical therapy would be necessary at this time. Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Neck and Upper Back: Physical Therapy.

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
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- 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)
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