

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/04/2009

**IRO CASE #:**

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

Physical Therapy 3x/week x 4 weeks A/PROM lumbar, 97010, 97014, 97035, 97140, 97124, 97110, 97530, 97116, 97113

**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)

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a xx year-old male who was injured while lifting boxes overhead and twisted on xx/xx/xx. In 2003 he underwent back surgery. Two months later the right side of his back began hurting. A lumbar MRI on 07/29/09 revealed multilevel lower lumbar spondylosis, mild spinal canal stenosis at L4-5 and L5-S1 and moderate left foraminal narrowing at L4-5. Dr. evaluated the claimant on 08/04/09 reporting back pain. On examination there was a positive straight leg raise on the right and tenderness to palpation of the spine. Lumbar spinal stenosis was diagnosed. Therapy, referral to Dr. for pain management and possible epidural steroid injections were recommended. An initial therapy evaluation on 08/06/09 noted off and on low back pain with right lower extremity numbness and functional limitations including prolonged sitting/standing, stairs, bending, lifting, squatting and ambulating long distances. Active motion was: flexion 30 percent of normal, extension 60 percent of normal, right lateral flexion 75 percent of normal, and left lateral flexion 50 percent of normal.

Strength was 4-/5 on the right lower extremity. Her right leg was approximately ¼ to ½ centimeter shorter. Therapy three times a week for four weeks was recommended. This was denied on 08/11/09 and 08/19/09 reviews and is currently under dispute.

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

This individual had lumbar surgery in 2003 as it relates to a vocational injury from xxxx. Apparently he has been through an extensive course of rehab in the past. His ongoing chronic complaints are felt to be nonsurgical in nature. Based on their chronicity there is no indication that further therapy is likely to offer any meaningful improvement over supervised

rehab which has been undertaken in the past. As such, this reviewer would agree with the previous reviewers to the extent that there is no indication in this particular case that the additional physical therapy recommended would offer any greater benefit than the supervised rehabilitation program that has been undertaken over the course of years of treatment following his vocational injury from xxxx. The reviewer finds that medical necessity does not exist for Physical Therapy 3x/week x 4 weeks A/PROM lumbar, 97010, 97014, 97035, 97140, 97124, 97110, 97530, 97116, 97113.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, (i.e. Low Back-Physical Therapy

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

ACOEM-AMERICA 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)