

# Clear Resolutions Inc.

An Independent Review Organization  
6800 W. Gate Blvd., #132-323  
Austin, TX 78745  
Phone: (512) 879-6370  
Fax: (512) 519-7316  
Email: resolutions.manager@cri-iro.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Oct/24/2011

**IRO CASE #:**

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

Left hip/left thigh physical therapy of three times a week for four weeks

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

M.D., Board Certified Physical Medicine and Rehabilitation

**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**

Official Disability Guidelines

Notification of adverse determination dated 07/26/11 recommending non-certification physical therapy x3 week x4 weeks, left hip/left thigh

Notification of reconsideration determination 09/01/11 recommending non-certification appeal physical therapy x3 week x4 weeks, left hip/left thigh

Pre-authorization request form 08/29/11

Pre-authorization request form 06/08/11

Physical therapy evaluation 08/29/11

Physical therapy initial examination 06/08/11

Office notes Dr. 03/25/11-10/05/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male whose date of injury is xx/xx/xx. He was injured secondary to a accident. Per office notes dated 03/25/11, he complained of neck and left shoulder pain. He also complained of discomfort, but no pain to the lower back and left hip. The claimant reported improvement in neck and shoulder pain, as well as low back pain, but continued to complain of pain to the left hip. He was treated conservatively with medications and physical therapy. The claimant reported he finished his physical therapy sessions on 07/14/11. He continued to complain of left hip pain.

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

Left hip/left thigh physical therapy of three times a week for four weeks is not found by the reviewer to be medically necessary. The patient is noted to have sustained multiple injuries secondary to accident. He initially complained primarily of neck and shoulder pain with some discomfort noted in the lumbar spine and left hip. His other complaints resolved, but he

continued with left hip pain. No diagnostic/radiology reports were provided with objective evidence of significant left hip pathology. The claimant did undergo a course of physical therapy with some improvement noted. However, there is no detailed physical examination provided with a thorough orthopedic examination including assessment of neuromotor function. As noted on previous reviews, the request for 12 additional sessions of physical therapy in addition to the therapy previously completed exceeds ODG recommendations. However, there is no documentation of exceptional factors that would support the need for therapy in excess of general guidelines either in number of visits or duration.

**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)