

# True Resolutions Inc.

An Independent Review Organization  
500 E. 4th St., PMB 352  
Austin, TX 78701  
Phone: (214) 717-4260  
Fax: (214) 276-1904  
Email: rm@trueresolutionsinc.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Nov/26/2013

**IRO CASE #:**

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

12 Physical Therapy visits for the Cervical Spine

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

Board Certified Neurosurgeon

**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 medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 10/03/13, 10/22/13

Handwritten cervical spine evaluation dated 09/30/13

Handwritten physical therapy note dated 11/05/13, 10/31/13, 10/29/13, 10/24/13, 10/22/13, 10/17/13, 10/14/13, 10/11/13, 10/08/13, 09/30/13, 10/03/13

Office note dated 09/30/13

Physical therapy mobilization sheet dated 09/30/13-10/17/13, 10/22/13-11/05/13

Cervical MRI dated 09/12/13

Weekly exercise/modality log dated 10/14/13-10/18/13, 10/07/13-10/11/13, 09/30/13-10/04/13, 11/04/13-11/08/13, 10/28/13-11/01/13, 10/21/13-10/25/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient felt instant right cervical, shoulder and thoracic pain. MRI of the cervical spine dated 09/12/13 revealed

small right posterolateral to foraminal disc protrusion at C4-5. This abuts the right C5 nerve root and causes moderate right foraminal stenosis. There is a tiny left paracentral disc protrusion at C3-4 without canal stenosis or cord deformity. There is uncovertebral and facet arthrosis with moderate bilateral foraminal stenosis at C5-6. Follow up note dated 09/30/13 indicates that cervical range of motion is flexion 50, extension 20, left side bending 25, right side bending 20, left rotation 70 and right rotation 45 degrees. Gross manual muscle testing mid scap strength is 4-/5.

Initial request for 12 physical therapy visits was non-certified on 10/03/13 noting that the only clinical documentation submitted for review was a two-page handwritten PT evaluation report from 09/30/13. The provider stated that he saw the patient on 09/24/13 and ordered requested services at that time. The provider stated the patient had not attended PT since his injury approximately 3 ½ weeks earlier. The provider was advised the requested number of sessions is not in accordance with these guidelines. A treatment modification of 6 visits was agreed to by the provider. The denial was upheld on appeal dated 10/22/13 noting that the patient attended six physical therapy visits with documented improvement. In accordance with the Official Disability Guidelines, a treatment modification of four visits was offered.

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

The patient is diagnosed with cervical strain/sprain. The patient has completed 10 visits of physical therapy to date. The Official Disability Guidelines support up to 10 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for 12 physical therapy visits for the cervical spine is not recommended as medically necessary.

**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)