

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/19/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: PT 2x4 Cervical spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

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. It is the opinion of this reviewer that medical necessity for PT 2x4 Cervical spine in this case has been established

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who sustained an injury on xx/xx/xx. The patient developed complaints of neck pain. The first clinical note was from 05/21/14 noting continuing complaints of neck pain despite initial use of anti-inflammatories both prescription and over the counter and chiropractic adjustments. MRI of the cervical spine was done. Physical examination noted limited range of motion in the cervical spine with evidence of weakness at the left triceps. Reflexes were trace to absent in the upper extremities bilaterally. The patient was assessed with spinal stenosis and cervical degenerative disc disease and cervical radiculopathy. The patient was recommended to attend physical therapy and undergo epidural steroid injections. The patient was seen for physical therapy evaluation on 05/28/14. Physical examination noted positive Spurling signs and positive drop arm sign. There was loss of range of motion in the cervical spine in all planes with moderate to severe weakness of the left shoulder on flexion abduction and rotation. The patient was recommended for physical therapy to improve strength and range of motion in the neck and left shoulder. The requested eight sessions of physical therapy was denied by utilization review on 06/03/14 as the patient had already been approved for eight sessions of physical therapy and the eight additional sessions recommended would have exceeded guideline recommendations. The request was again denied by utilization review on 06/16/14 as there was no documentation of exceptional indicators for therapy extension or reasons why a prescribed independent home exercise program would have been insufficient to address any remaining functional deficits.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The clinical documentation submitted for review does not indicate the patient has ever been approved for physical therapy following the date of injury in question. The 05/21/14 clinical record only noted that the patient had utilized medications and seen a chiropractor. No formal physical therapy had been previously documented for this patient. Physical examination findings and reported imaging findings are consistent with cervical spine degenerative disc disease that was symptomatic.

Per guidelines this would allow for 10-12 sessions of physical therapy. The eight sessions requested would be reasonable and medically appropriate based on guideline recommendations. Therefore it is the opinion of this reviewer that medical necessity for PT 2x4 Cervical spine in this case has been established and the prior denials are overturned.

**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)