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An Independent Review Organization

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IRO REVIEWER REPORT

Date: 2/19/2018 12:38:44 PM CST

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Physical Therapy 2X4 cervical, thoracic

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|--------------------------------|
| <input type="checkbox"/> Overturned | Disagree |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input checked="" type="checkbox"/> Upheld | Agree |

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a XXXX with history of an occupational claim from XXXX. The mechanism of injury was not detailed the documentation provided for review. The clinical note from XXXX notes the patient is stable at this time. The patient was seen for refill of medications. There was pain elicited over the cervical fifth, sixth and seventh spinous process. Sensation was intact. There was 2/4 biceps, brachioradialis and triceps deep tendon reflexes. The patient had 5/5 strength to upper extremities. Range of motion was limited with extension and flexion, left lateral flexion right lateral flexion, left rotation right rotation.

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

The Official Disability Guidelines note that up to 10 visits over 8 weeks is recommended. The documentation indicates that the patient has previously received physical therapy. There was no clear evidence of patient's objective functional improvement or decrease in pain with the previous physical therapy visits. Also, the request exceeds guideline recommendations. There was no evidence of any significant exceptional factors to warrant the need to exceed guideline or conditions.

As such, the requested Physical Therapy 2x4 cervical, thoracic is not medically necessary and the prior determination is upheld.

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
- AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Neck and Upper Back, Physical therapy (PT)