

Applied Assessments LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 07/01/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ACS services

A 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)

Upon independent review the reviewer finds that the requested ACS services are not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 6/4/08, 6/12/08
ODG Guidelines and Treatment Guidelines
MD 6/6/08, 5/29/08, 4/10/08, 2/7/08, 8/9/07, 6/12/07, 5/10/07, 4/17/07, 1/2/07, 8/15/06,
6/13/06, 5/30/06, 4/25/06, 2/21/06, 1/17/06, 3/10/05, 4/20/04, 3/10/04, 2/4/03, 1/14/03,
9/6/01, 6/21/01, 4/5/01, 9/14/00, 6/13/00, 5/4/00, 2/29/00, 11/2/99, 10/12/99, 9/22/99
Pre-Authorization Requests

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male injured worker with a date of injury of xx/xx/xx who has undergone previous back surgery, spinal cord stimulator implantation, and is being managed with pain management with multiple trigger point injections and injection of Toradol and office visits, as well as a previous history of Botox injection. Current request is for ACS services.

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

Upon independent review of the provided medical records and ODG Guidelines, this reviewer finds that the requested ACS services are not medically necessary. This is a patient who has a spinal cord stimulator implantation. He is using it only minimally, at times only 5%. This would indicate either minimal efficiency or minimal requirement for neural modulation. The patient is receiving Toradol injections on an intermittent basis. The patient is reported to have multiple trigger points as well as a positive iliopsoas maneuver. However, there is no connection made by the medical provider as to how this impacts upon his current level of discomfort or how this is indicative of a “myofascial dysfunction.” Because of this, the medical necessity for trigger point injection cannot be established at this time based on the records provided. Similarly, the medical necessity for third compartment block under fluoroscopy has not been established at this time. Please refer to Official Disability Guidelines, 2008, trigger point injections.

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
- AHCP- 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)**