

SENT VIA EMAIL OR FAX ON
Jul/29/2009

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/29/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Letter of Denial/Non-Certification of Services: 06/18/09 & 07/02/09 denied PT -- DOS = 06/16/09 to 07/16/09

Dr. Office Records: 04/14/09; 04/16/09; 04/21/09; 04/24/09; 04/27/09; 04/30/09; 05/05/09; 05/07/09; 05/14/09; 05/22/09

MRI Lumbar Spine: 04/20/09

W/C Notice to Insurance Company of Assignment: 05/27/09

Dr. Office Notes: 06/04/09

Physical Therapy Initial Evaluation: 06/11/09

Peer Reviews: 06/17/09 & 07/01/09

PATIENT CLINICAL HISTORY SUMMARY

This xx year old male sustained a lifting injury to his low back on xx/xx/xx with an initial diagnosis of left sciatica, left hip sprain complex; acute lumbar sprain and lumbar disc

syndrome. Documentation reveal an initial evaluation at a urgent care clinic and the claimant then underwent 10 chiropractic treatments with reported improvement in his left leg pain but continued low back pain. A lumbar MRI performed on 04/20/09 demonstrated degenerative disc disease at L3-4 with minimal bulging and L5-S1 desiccation with a left central subarticular disc herniation protrusion causing displacement of the left S1 nerve root.

An orthopedic evaluation completed on 06/04/09 revealed no abnormal exam findings with a current diagnosis of lumbar sprain and disc displacement. A physical therapy evaluation completed on 06/11/09 revealed a slight reduction in the left gastroc reflex, some limitations in EMG/NCV studies with tightness of the trunk and lower extremity musculature and limited function and physical therapy was recommended.

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

The requested physical therapy in general may be supported, as there is no record the claimant has previously received therapy. However, the most recent record appears to recommend therapy for 12 sessions following the initial therapy visit. ODG guidelines only allow up to 10 visits over 8 weeks.

Despite two previous peer reviews, which did not support the therapy request, the request still has not been altered to fall within typical guidelines. Therefore, the clinical records do not support the medical necessity of the request based on ODG criteria.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates: Low Back – physical therapy

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A

DESCRIPTION)

**[] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE A DESCRIPTION)**