

SENT VIA EMAIL OR FAX ON
Jul/07/2009

Applied Resolutions LLC

An Independent Review Organization

1124 N Fielder Rd, #179

Arlington, TX 76012

Phone: (512) 772-1863

Fax: (512) 853-4329

Email: manager@applied-resolutions.com

DATE OF REVIEW:

Jun/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions of Active Physical Rehabilitation between 5/28/2009 and 7/27/2009

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 5/22/09 and 6/2/09

Pain & Recovery 5/15/09 thru 6/22/09

Dr. 2/25/09

Peer Review 3/25/09

Dr. 4/29/09 thru 5/18/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man who drove his truck when injured on xx-xx-xx. The truck rolled over as the ground gave way. He reportedly sustained a closed head injury, cervical thoracic and lumbar pain, right knee and ankle and right shoulder injuries. Although the ankle xrays were normal, an MRI suggested blunt trauma with marrow edema and a possible distal tibial fracture.

Dr. felt he had radiulitis and of the cervical and lumbar region with thoracic sparin and internal derangement of the right shoulder and ankle. There was no neurological loss. The right shoulder and knee pain improved. His right ankle continued to cause problems. He had Physical therapy for the shoulder and spine and ankle. There is a request for additional physical therapy, as this man had not reached, per Dr. his preinjury functional level.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The issue remains the pain in the back and ankle. Right shoulder and knee problems resolved. Dr. May 15, 2009 note describes the person on that date. No therapy notes were provided to document his participation or progress. Since he is not symptomatic of the knee and shoulder, these sites are not reviewed.

Physical Therapy can be justified for back strain for 10 sessions over 8 weeks. There was no evidence of a radiculopathy. Cervicalgia and brachial neuritis can be treated with 9-12 visits over 8-10 weeks. A fracture ankle can warrant 12 sessions over 12 weeks. He already had physical therapy. The 12 sessions requested are in addition to the prior therapies. Without knowing how he did with those therapies, there is no information provided to support a variance from the ODG treatment recommendations.

Lumbar sprains and strains (ICD9 847.2)

10 visits over 8 week

Sprains and strains of unspecified parts of back (ICD9 847)

10 visits over 5 week

Sprains and strains of sacroiliac region (ICD9 846)

Medical treatment: 10 visits over 8 week

Lumbago; Backache, unspecified (ICD9 724.2; 724.5)

9 visits over 8 week

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8)

Medical treatment: 10 visits over 8 weeks

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)