

SENT VIA EMAIL OR FAX ON
Jul/05/2010

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy Lumbar/Thoracic/Cervical X 6 sessions 2 units per session; Therapeutic Activities Lumbar/Thoracic/Cervical X 6 sessions 2 units per session; Manual Therapy Lumbar/Thoracic/Cervical X 6 sessions

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

AADEP Certified

Whole Person Certified

Certified Electrodiagnostic Practitioner

Member of the American of Clinical Neurophysiology

Chiropractor Physician

Clinical practice 10+ years in Chiropractic WC WH Therapy

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 5/25/10 and 6/2/10

Chiropractic Clinic 2/17/10 thru 6/23/10

Services of Irving 2/2/10 thru 2/8/10

PPB Test 4/16/10

IRO Summary 6/23/10

Lumbar Spine 2/16/10

NCV/EMG 3/15/10

MRI 3/26/10

Dr. 4/24/10

PATIENT CLINICAL HISTORY SUMMARY

The injured worker was injured on xx/xx/xx. The injured employee was injured when she slipped and fell. The injured employee injured her spine and right upper and lower extremity. The injured employee underwent x-rays, muscle testing, neuromuscular testing, EMG/NCV, MRI cervical spine, medication, physical therapy, E-stim, and had seen multiple providers. A peer review was performed on 4-24-2010. Six (6) sessions of activity and manual physical therapy are now being requested.

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

The injured employee has completed over 26 sessions of therapy. Records do not support going outside the guidelines of 10 sessions.

Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0):

9 visits over 8 weeks

Sprains and strains of neck (ICD9 847.0):

10 visits over 8 weeks

Displacement of cervical intervertebral disc (ICD9 722.0):

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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