

SENT VIA EMAIL OR FAX  
ON Jul/25/2011

# Applied Assessments LLC

An Independent Review  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/25/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

12 physical therapy visits over 4 weeks for the lumbar

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

Board Certified Family Practice

**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**

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. It appears that on this date the patient was involved in a motor vehicle accident wherein she was rear-ended by a large truck. The earliest clinical record submitted for review is an office visit note dated 05/12/11. The patient presents with complaints of headache with onset date approximately x months ago. The location is primarily left and right occipital. The patient is noted to be status post L3-S1 fusion in 1994 with hardware removal in 1995 and right carpal tunnel

surgery in 2010. The patient has undergone physical therapy for the past 6 weeks. Note dated 06/16/11 indicates that medications include Flexeril, ibuprofen, Prozac and Vicodin. The patient complains of chronic low back pain. On physical examination gait is antalgic. Lumbar range of motion is decreased with flexion and lateral flexion. There is tenderness noted throughout the entire lumbar spine worst just superior to the right iliac crest.

Initial request for physical therapy was non-certified on 06/23/11 noting that there is no documentation that the patient has been involved in an ongoing home exercise program as would be expected following fusion surgery. The denial was upheld on appeal dated 07/07/11 noting that the patient's treatment history is not documented, and there are no therapy notes.

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

The request for 12 physical therapy visits over 4 weeks for the lumbar is not recommended as medically necessary, and the two previous denials are upheld. The patient sustained injuries over xx years ago; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient reportedly underwent a recent course of physical therapy; however, the patient's objective, functional response to this therapy is not documented. The patient's compliance with a home exercise program is not documented. There are no specific, time-limited treatment goals provided. Given the current clinical data, the requested physical therapy is not indicated as medically necessary.

**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)