

SENT VIA EMAIL OR FAX ON
May/10/2011

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/10/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy to right hand and wrist, and lumbar spine 3 times per week for 4 weeks, outpatient

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

Board Certified Anesthesiologist/Pain Management

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

1. Cover sheet and working documents
2. Utilization review determination dated 04/19/11, 01/10/11
3. Office visit note dated 04/11/11, 12/27/10, 12/15/10, 12/13/10
4. Patient referral forms
5. Handwritten progress note dated 04/08/11, 03/23/11, 03/14/11
6. Letter dated 03/31/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. The patient reports that he injured his right hand and back secondary to repeatedly lifting 300 lb poles. Progress note dated 12/27/10 indicates that on physical examination of the right hand there is no swelling or deformity. Grip strength is normal. Interosseous muscle strength is normal. Finkelstein's is negative. Tinel's and Phalen's are negative. There is no tenderness of the right hand, and the remainder of the hand examination was unremarkable. Evaluation dated 04/11/11 indicates that the patient ambulates with a guarded gait. There is tenderness to palpation of the lumbar spine bilateral of midline, worse on the left. Lumbar range of motion is decreased in all planes with discomfort at end ranges. Deep tendon reflexes are 2+/4 in the bilateral lower extremities. Sensation is intact. Straight leg raising is positive bilaterally.

The request for physical therapy to right hand and wrist and lumbar spine 3 x week x 4 weeks was non-certified on 04/19/11 noting that the patient's physical examination is unremarkable.

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

Based on the clinical information provided, the request for physical therapy to right hand and wrist, and lumbar spine 3 times per week for 4 weeks, outpatient is not recommended as medically necessary, and the previous denial is upheld. The patient sustained an injury in xx/xx/xx and has completed a course of physical therapy. Progress note dated 12/27/10 indicates that physical examination is grossly unremarkable. There is no clear rationale provided to support ongoing physical therapy at this time. There are no specific, time-limited treatment goals provided. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES