

SENT VIA EMAIL OR FAX ON  
Aug/31/2011

## Applied Assessments LLC

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/31/2011

**IRO CASE #:**

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

Physical Therapy 3 X wk X 4 wks

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

PMR

**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. Request for IRO dated 08/23/11
2. Utilization review determination dated 07/22/11
3. Utilization review determination dated 08/11/11
4. Fax cover sheet dated 08/19/11
5. Letter of appeal request for IRO dated 08/15/11
6. Treatment records D.C. 07/16/11, 08/04/11
7. Utilization review determination
8. Consultation note Dr. dated 01/16/03, 07/24/03, 08/21/03, 12/18/03, 03/11/04, 04/15/04, 06/08/04, 08/24/04, 12/07/04, 03/22/05, 07/24/06, 09/12/07, 10/24/07, 01/18/08, 03/05/08, 08/20/08, 02/13/09, 07/15/09, 10/19/09, 02/10/10, 05/12/10, 08/25/10, 12/06/10, and 04/28/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xxxx. She is reported to be employed. She is noted to have diagnosis of bilateral carpal tunnel syndrome, ultimately undergoing carpal tunnel release on right side. She has further received diagnoses which include bilateral shoulder strains. The submitted clinical records indicate the claimant has undergone extensive conservative treatment in the past, given that the date of injury is 10 years old. Per the most detailed record, the claimant has received injections into the forearms and wrist. She has previously had EMG. She later underwent carpal tunnel release. She had surgery over the right elbow on 10/14/02. She is

noted to have had postoperative physical therapy as a result of these injuries. Records from Dr. indicate chronic depression. The claimant has largely been maintained on oral medications.

A request for physical therapy 3 times a week for 4 weeks was initially reviewed by Dr. Dr. notes that the injury is 10 years old and is doubtful that physical therapy this far removed from date of injury would be of any benefit. He subsequently denied the request.

An appeal request was submitted and reviewed by Dr. D.C. Dr. notes that physical therapy 3 times a week for 4 weeks was non-certified. He notes the claimant has complaints of pain and restriction of movements in neck, shoulder, elbow, hand and wrist. ODG recommends 9-10 visits for injury. He noted the limited clinical information does not provide any data regarding prior home exercise program or physical therapy treatments. He finds the request most likely exceeds guidelines and is non-certified.

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

The request for physical therapy 3 x 4wks is not supported by the submitted clinical information. The claimant is 10 years post date of injury with original injuries being reported to bilateral wrists. She subsequently underwent surgery and had postoperative physical therapy. She later underwent surgery to right elbow and had postoperative therapy for this. The claimant has chronically been maintained on oral medications. There are no detailed examination results that would suggest the claimant would benefit from additional physical therapy to the neck or bilateral shoulders. As such, the request is not medically necessary, and previous utilization review determinations are upheld.

**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**