

# Applied Resolutions LLC

An Independent Review Organization

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## **Review Outcome:**

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Orthopedic Surgery

## **Description of the service or services in dispute:**

12 physical therapy three times a week for four weeks

**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)

## **Patient Clinical History (Summary)**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped and fell on a wet floor. The earliest note submitted for review indicates that the patient sustained injury to the right knee and thigh. He has had physical therapy and now has started to walk. Diagnosis is listed as femur fracture. Normal x-rays reportedly revealed no acute changes. Note dated 10/29/14 indicates that the patient continues to complain of pain to the right leg. Follow up note dated 11/12/14 indicates that the patient has not started with therapy yet. He continues with pain. Current medications are Ultram, Ibuprofen, Tylenol with codeine #3, amlodipine, lisinopril. On physical examination the patient's gait is antalgic with Trendelenburg gait. Examination of the right hip reveals no swelling, edema or erythema, no instability, subluxation or laxity. Sensation and coordination are normal.

The initial request for 12 physical therapy three times a week for four weeks was non-certified on 10/30/14 noting that the documentation from 10/08/14 indicates that the claimant has already undergone therapy. It is questionable how much therapy was at this point. The denial was upheld on appeal dated 11/05/14 noting that the note dated 10/08/14 indicates that the patient has not had any surgery, was in a wheelchair for four months after the injury and has received some physical therapy. The rehabilitation referral form states that the patient had sustained a hip fracture. It is unusual for an adult patient to sustain a hip fracture that does not require surgery. There is no x-ray interpretation available. Specifics of the hip injury are unclear by the records provided. The number of previous therapy visits received and the patient's progress with those sessions are not available. It is unknown if the patient needs to continue with formal PT. There are also no reasons stated as to why the patient cannot continue with a self-guided home exercise program.

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***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

The patient sustained injuries on xx/xx/xx. The earliest record submitted for review is dated 10/08/14. This note states that the patient has undergone some physical therapy. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The number of physical therapy visits completed to date is not documented. The patient reportedly sustained a femur fracture; however, there are no radiographic reports submitted for review. The patient's compliance with an active home exercise program is not documented. Therefore, medical necessity is not established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for 12 physical therapy three times a week for four weeks is not recommended 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 and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)