

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.

DATE OF REVIEW: March 28, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy 3x week x 4 weeks - 12 visits

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

Internal medicine, occupational and environmental medicine

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

Medical records from the URA/Carrier include:

- 02/09/07, 03/09/07, 03/22/07
- Center, 07/14/06
- M.D., 10/25/06
- Healthcare, 01/03/07, 01/27/07
- Diagnostic, 01/06/07

Medical records from the Requestor include:

- Texas Department of Insurance, 03/19/07
- Center, 07/14/06
- Healthcare, 09/18/06, 09/23/06, 10/13/06, 10/28/06, 10/30/06, 11/06/06, 02/24/07

March 28, 2007

Page 2 of 3

- 02/09/07, 03/09/07

PATIENT CLINICAL HISTORY:

This is a male who reports injury when involved in a motor vehicle accident. The patient has complained of persistent cervical pain. He has had over 20 visits of physical therapy as well as cervical epidural steroid injections.

An MRI scan has shown disc protrusions at the C4-C5, C5-C6, and C6-C7 levels. The patient also complained of lumbar pain. Disc protrusions are noted at the L4-L5 and L5-S1 levels.

Additional physical therapy has been suggested for this patient. Proposed treatment is physical therapy three times a week for four weeks with a total of 12 visits.

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

The available medical records support no objective improvement in this patient after having undergone approximately 20 physical therapy visits. The physical findings do not suggest that he will benefit from any additional physical therapy. He should continue a self-directed home physical therapy program.

References to be noted are American College of Occupational & Environmental Medicine Practice Guidelines, Second Edition, and ODG Treatment in Workers' Compensation 2006, Fourth Edition, page 1119.

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

- ACOEM- AMERICAN 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)**