

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: April 10, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions of physical therapy to include:
97001 – Physical therapy evaluation x 1
97014 – Electrical stimulation (unattended) x 12
97035 – Ultrasound x 12
97033 – Iontophoresis x 12
97110 – Therapeutic exercises x 12
97112 – Neuromuscular reeducation x 12
97140 – Manual therapy x 12
97530 – Therapeutic activities (one on one) x 12

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

Diplomate, American Board of Orthopaedic Surgery

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)

PATIENT CLINICAL HISTORY:

The records indicate that the patient is a male who was injured while working as a firefighter. He was doing physical training and developed sharp pain in his lower back.

The patient was treated by a chiropractor from the date of injury through March 4, 2008, at which point he was referred to M.D. There were no radiating pains into the lower extremities. Dr. indicated in his physical examination that reflexes were symmetric with mild weakness of the left iliopsoas due to giveaway weakness. Dr. provided a diagnosis of lumbago. He noted on the MRI that there were changes consistent with degenerative disc disease. He saw no indication for any surgical intervention. Further physical therapy with a MacKenzie back program was recommended.

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

It is my opinion that the denial for further physical therapy was appropriate. The ODG Guidelines support the need for ten physical therapy visits following a lumbar strain, which the patient underwent. Continued physical therapy is not supported by the ODG. The adverse determination appears appropriate.

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)**