



REVIEWER'S REPORT

DATE OF REVIEW: 07/09/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical medication and rehabilitation services.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., D.O., M.S., Board Certified in Chiropractic, Physical Medicine and Rehabilitation, Pain Management

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. I reviewed the denial for physical medicine to the lumbar spine directed by Dr. dated 06/20/08. The request was for fifteen minutes of electrical muscle stimulation, therapeutic exercises for thirty minutes, massage and neuromuscular re-education for a total of ten sessions, twice weekly for five weeks.

2. I reviewed a 06/04/08 note from Healthcare Center. This was authored by Dr. . The injured employee had limited mobility in the spine. The note states, “Patient’s condition has shown minimal improvement.” She was diagnosed with lumbar intervertebral disc without myelopathy, lumbago, or sciatica due to displacement of intervertebral disc, neuritis or radiculitis due to displacement or rupture of lumbar intervertebral disc.

3. There was a note dated 06/30/08 from Dr. indicating the patient has had no therapy directed to her lumbar spine, but rather the therapy was directed to her shoulder. This, however, would contradict the notes, specifically of 06/04/08, indicating that the

complaints were of the lower back, the exam was of the lower back, and the treatment goals pertained to the lower back.

4. I reviewed a radiology report, which was an MRI scan of the cervical spine, which showed a disc protrusion at the C2/C3 level, C3/C4 level, C4/C5 level, and a disc extrusion at the C5/C6, and a protrusion of the C6/C7 level and C7/T1 levels. This was irrelevant to the lower back examination and treatment that was apparently provided, however.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

There is very little medical history with respect to this individual's condition. The only reference that I was able to identify was that there was a lower back injury that apparently occurred at work on xx/xx/xx, but the details of that event are unknown, as they are not documented in the medical records that I have been provided for my review today.

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

This individual appears to have had a low back strain. It appears as though she had ten sessions of physical therapy, and according to the treating physician, had made minimal gains. There was really no objective assessment of progress identified in the records. According to the online version of the ODG Guidelines, it is recommended physical therapy be administered ten times over eight weeks. This individual appears not to have benefited from the ten sessions she has had, and there has been no post therapy assessment of a comparative nature with which to identify any objective evidence of improvement. It is for these reasons I do not believe further therapy is indicated.

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

(Check any of the following that were used in the course of your review.)

- 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 judgment, 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 national accepted medical literature (provide a description).

_____ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)