

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
12001 NORTH CENTRAL EXPRESSWAY
SUITE 800
DALLAS, TEXAS 75243
(214) 750-6110
FAX (214) 750-5825

Notice of Independent Review Decision

DATE OF REVIEW: June 4, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional physical therapy to the lumbar area, 3 times a week times 4 weeks for 12 sessions, to include CPT codes #97113, 97110, 97124, 97140, 97010, G0283, 97035.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY:

I have had the opportunity to review medical records on this patient. The records indicate that the patient was a female who injured her right shoulder and lower back while walking on stairs. She slipped and fell.

The patient eventually reported to where she was evaluated by M.D. A review of Dr. 's physical examination indicated mild tenderness with bilateral deep tendon reflexes, negative straight leg raise, and normal strength. He provided a diagnosis of low back pain. He recommended an MRI of the lumbar spine and the right shoulder.

An MRI scan of the lumbar spine disclosed multilevel degenerative disc disease with a small left central herniation at L4-5 and a small right foraminal disc herniation at L5-S1.

Following the MRI scan, the patient returned to see Dr. Physical therapy was prescribed.

The patient was referred to M.D., who recommended an epidural injection.

Dr. subsequently recommended shoulder surgery.

An arthroscopic rotator cuff repair was performed on October 23, 2008. Physical therapy was prescribed postoperatively.

The patient returned to see Dr. on November 19, 2008. He recommended a full duty work release.

By February 9, 2009, the patient had full range of motion with continued weakness.

The final entry into the medical records is dated March 30, 2009, from Dr. This indicates recommendations for continued full duty work and an impairment rating.

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

It is my opinion that the adverse determination for physical therapy was within the ODG Guidelines. There is no evidence in the records provided to me of any ongoing lower back conditions. There has never been any evidence of radiculopathy. The ODG does provide for ten visits over the initial eight weeks following a lumbar sprain/strain. This timeframe has long since lapsed. Therefore, based upon the ODG and the current lack of any documentation of lumbar abnormalities, it is my opinion that the adverse determination for further physical therapy is 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)**