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

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Notice of Independent Review Decision

**DATE OF REVIEW:** October 27, 2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Physical therapy dates of service: 5/5/04, 5/6/04, 5/7/04, 5/10/04, 5/11/04, 5/12/04, 5/13/04, 5/14/04, 5/17/04, 5/18/04, 5/19/04, 5/20/04, 5/21/04, 5/24/04, 5/25/04, 5/26/04, 5/28/04, 6/1/04, 6/2/04, 6/3/04, 6/4/04, 6/7/04, 6/8/04, 6/9/04, 6/10/04, 6/11/04, 6/14/04, 6/15/04, 6/16/04, 6/17/04.

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

Diplomate of the American Chiropractic Neurology Board

**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:**

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Per the Employer's First Report of Injury or Illness, the patient injured herself on xx/xx/xx. She reportedly was lifting an ice chest.

The patient went to the emergency room on xx/xx/xx. X-rays were taken and a lumbar MRI was taken that revealed degenerative changes at L4-5 and L5-S1. There was no evidence of neuroforaminal narrowing or spinal narrowing. She was diagnosed with an L5-S1 disc herniation. She was prescribed Flexeril and Motrin.

The patient went to D.C., on May 9, 2003. She was diagnosed with a herniated disc there. She underwent physical therapy.

The patient then saw D.C., on May 23, 2003, a chiropractor who did aquatic therapy.

The patient had a normal EMG/nerve conduction study on June 17, 2003.

The patient then went to the Texas Work Comp Clinic on July 7, 2003.

The patient underwent a functional capacity evaluation on July 21, 2003, that matched her functional capacity evaluation level.

The patient was seen by Dr. on July 28, 2003. Her deep tendon reflexes were equal bilaterally. He recommended additional therapy.

The patient saw M.D., on August 15, 2003. She was noted to have 5/5 motor strength, 2+ deep tendon reflexes, and no atrophy. She had equal leg lengths. She was able to toe and heel walk. There was an L5-S1 protrusion, and she was referred for steroid injections. These were performed on November 17, 2003, December 11, 2003, and February 5 2004. The patient was recommended to a chronic pain management program on March 16, 2004. On April 14, 2004, the patient had a functional capacity evaluation that revealed her physical demand level was light. She was able to function at that level. On May 13, 2004, M.D. reviewed the records. He indicated that the changes were mainly chronic and unrelated to the reported injury and that most of the treatment should have been concluded within three weeks to three months after the injury.

On May 5, 2004 through July 17, 2004, the patient completed work hardening and was released to work without restrictions by M.D. on June 23, 2004.

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

There is a request for further treatment in the records for work hardening/work conditioning and physical therapy. Based on the information provided, I would uphold the previous denial decisions. Based on the Official Disability Guidelines of 2008, dates of service from May 5, 2004 through June 17, 2004 were neither reasonable nor necessary.

**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

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- 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**

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- 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)**