



# Lumetra

Brighter insights. Better healthcare.

One Sansome Street, Suite 600  
San Francisco, CA 94104-4448

415.677.2000 Phone  
415.677.2195 Fax  
www.lumetra.com

## Notice of Independent Review Decision

**DATE OF REVIEW:** 9/20/09

**IRO CASE #:**

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

Physical Therapy 3xwk x 8 wks Lumbar

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

Certified by the American Board of Orthopaedic Surgery

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective		95851	Overturned
		Prospective		97035	Overturned
		Prospective		97140	Overturned
		Prospective	724.2	97112	Overturned
		Prospective	846.0	97110	Overturned

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physical Therapy Evaluation/notes dated 2/25/09, 6/2/09

MRI report dated 4/28/09

**Notice of Independent Review Decision**  
**Page 2**

Electrodiagnostic Study dated 7/1/09  
Physician notes dated 6/1/09, 6/23/09, 7/24/09, 8/7/09  
Official Disability Guidelines cited –Low Back Chapter, Physical Therapy, and  
Lumbago; Backache, unspecified

**PATIENT CLINICAL HISTORY:**

This claimant was injured on xx/xx/xx while lifting boxes at work. Diagnosed with sprain of the lumbosacral lower back. Treatment has included physical therapy and medications. The 8/7/09 evaluation noted that the claimant continues to complain of pain to left side of lower back that radiates to left side of buttocks and lower leg. Also continues to experience tingling and numbness intermittently. Additional Physical therapy was recommended.

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

In the Reviewer's opinion, the requested service should be authorized as requested. The Reviewer noted that this claimant is already over 6 months post injury, and that all conservative spine therapy and workup has been necessary and appropriate at this time. The Reviewer also noted that this claimant has radicular symptoms and on exam showed both combination instability and facet arthrosis syndrome. Electrodiagnostic testing as well as MRI and physical examination have all confirmed the above instability. Therefore, the requested service is appropriate and falls within the ODG Guidelines for lumbar sprains.

**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**

**Notice of Independent Review Decision**  
**Page 3**

- 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)**