

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

DATE OF REVIEW: June 28, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy once a week for 2 weeks. CPT Codes: 97110 x 3, 97112.

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

AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION
FELLOW, AMERICAN ACADEMY OF DISABILITY EVALUATING PHYSICIANS
FELLOW, AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION

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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

Medical records from the Carrier/URA include:

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Medical records from the Provider include:

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PATIENT CLINICAL HISTORY:

Description of the Services or Services in Dispute:

Physical therapy once a week for two weeks. CPT codes include 97110 x 3 and 97112.

Description of Qualifications for Each Physician or Other Health Care Provider Who Reviewed the Decision:

American Board of Physical Medicine Rehabilitation
American Academy of Independent Medical Evaluators

Review Outcome:

Upon independent review, the reviewer finds that the previous adverse determination should be upheld.

The patient originally presented in xx/xx/xx, status post a fall from approximately five to six feet onto his buttock and low back.

The patient subsequently required both conservative and surgical interventions for an injury sustained to his low back. These included surgical intervention with eventual surgical fusion of the L4-5 and L5-S1 levels.

The records reflect that the patient has not seen a formal work-related injury physician since 2006. The patient, however, does receive current treatment for his condition at Parkland Medical Center. This reportedly includes Lortab as part of his pain control.

The patient has recently been evaluated by, M.D., in May of 2010, for his low back condition and his work-related injury from xx/xx/xx.

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

Upon review of the medical records provided and based on the 2009 ODG Guidelines, the medical necessity is not clearly established for the provision of a home exercise program (HEP) re-evaluation by physical therapy in a patient presenting with chronic low back pain, without any appreciable change in clinical condition, and not currently participating in a previously recommended and prescribed independent home exercise program (HEP). It would be reasonable and appropriate to have the patient's current primary treating physician review previous home exercise program (HEP) and answer any questions or concerns that could be contributing to the absence of current participation in a home exercise program (HEP). The information gained by current clinical examination documented could then be integrated into a revised home exercise program (HEP), reflecting treatment goals established by the patient and the primary treating physician. This recommendation is within the scope and practice of the treating physician who is board-certified in physical medicine and rehabilitation.

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)