

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

DATE OF REVIEW: September 26, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Conditioning Program, 10 sessions over four weeks.

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

CHIROPRACTOR

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:

- Official Disability Guidelines, 2008
- Medical Centers, 04/14/10, 04/15/10, 04/19/10, 04/23/10, 05/03/10, 05/05/10, 05/06/10, 05/12/10
- Certificate of Medical Necessity and Prescription, 04/19/10
- , 04/22/10
- , 04/29/10, 05/13/10, 08/04/10, 08/24/10, 09/10/10
- Diagnostic MRI, 05/18/10
- D.C., 05/26/10, 06/02/10, 06/04/10, 06/07/10, 06/11/10, 06/14/10, 06/16/10, 06/18/10, 06/21/10, 06/23/10, 06/25/10, 06/28/10, 06/30/10, 07/03/10, 07/06/10, 07/08/10, 07/09/10, 08/05/10, 08/18/10, 08/25/10
- M.D., 07/15/10
- M.D., P.A., 08/04/10
- Texas Workers' Compensation Work Status Report, 08/05/10
- Request for a Review by an Independent Review Organization, 09/16/10

Medical records from the Provider include:

- Diagnostic MRI, 05/18/10
- Texas Workers' Compensation Work Status Report, 06/01/10, 07/03/10, 08/05/10, 08/25/10, 09/07/10
- D.C., 06/01/10, 06/02/10, 07/08/10, 07/09/10, 08/25/10
- , 08/24/10, 09/10/10
- Request for a Review by an Independent Review Organization, 09/16/10

PATIENT CLINICAL HISTORY:

The patient presented to in the office of D.C., on June 1, 2010, for evaluation and treatment of a work-related injury that occurred on. According to the patient, he was attempting to load a 45-pound gas valve onto a pallet when he felt immediate burning pain in his lower back.

To date, the patient has completed a total of 21 physical therapy sessions, nine visits with , and twelve visits with.

An MRI performed on May 18, 2010, revealed the presence of minor disc bulging at L3-4, L4-5, and L5-S1. In addition to the disc bulge, there was bilateral facet hypertrophy noted at L5-S1, resulting in slight impingement

of the L5 nerve root bilaterally. It was determined that the degenerative changes were the result of a pre-existing condition. The patient's compensable injury was diagnosed as a lumbar sprain/strain.

After no success to significantly improve after 21 sessions of physical therapy, the patient was referred for epidural steroid injections, however, the procedure was denied.

After completing his initial course of physical therapy with, the patient transferred to Dr.. Dr. performed a functional capacity evaluation on June 2, 2010. The results of which revealed that the patient functioned at a light physical demand level.

After completing an additional 12 sessions of physical therapy with Dr., the patient underwent a second functional capacity evaluation. The results of which revealed that the patient now functioned at a sedentary physical demand level.

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

After completing his initial course of physical therapy, a functional capacity evaluation performed on June 2, 2010, revealed that the patient functioned at a light physical demand level. After completing another 12 sessions of physical therapy, a repeat functional capacity evaluation was performed on July 9, 2010. The results of which revealed that the patient now functioned at a sedentary physical demand level.

Based on the results of the functional capacity evaluation, it appears the patient has made no significant objective functional improvement up to this point. As such, a more strenuous program would not improve his condition since the patient made no significant improvement with a less strenuous program. The ODG Guidelines criteria for entry to a work conditioning program requires the patient to have undergone an adequate physical therapy program revealing objective functional improvement followed by a plateau.

Based on the above mentioned results, the patient revealed no objective functional improvement. It appears the patient's performance actually was reduced to a lower level after the second functional capacity evaluation. My recommendation is a non-approval for the ten sessions of work conditioning.

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)