



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: 12/05/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OUTPATIENT PHYSICAL THERAPY (3) THREE TIMES PER WEEK FOR (1) ONE WEEK RELATED TO THE LUMBAR SPINE, CONSISTING OF ELECTRICAL STIMULATION, ULTRASOUND AND MASSAGE.

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

M.D. Board Certified in Occupational Medicine/ Urgent Care Medicine.

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)



14785 Preston Road, Suite 550 | Dallas, Texas 75254
 Phone: 214 732 9359 | Fax: 972 980 7836

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	11/15/2011
Utilization Review Determinations	4/19/2006, 9/27/2011-10/12/2011
Clinical Notes in Packages of 300 pages including: Orthopedics family Clinic Neurological Institute Pain Injury Center Notes M.D. History and Physical Outpatient Surgery Center- Operative Report Comprehensive Pain Management H&P Medical Center Hospital- Operative Report	5/10/2002-2003 6/20/2002 6/15/2002 8/09/2002-2003 7/12/2002 5/11/2006 6/26/2006 4/02/2003
Texas Workers' Compensation Work Status Reports	7/02/2002-2004
Notice of Utilization review Findings	2/19/2007
Chiropractic Pre Authorization Letter of Reconsideration	9/09/2011 9/20/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured worker, Mr. is a with chronic low back pain associated with an industrial injury of xxxx. Thus far, he has been treated with the following: Analgesic medication, adjuvant medications, multiple lumbar spine surgeries, and multiple epidural steroid injections.

Per a progress note dated 2007, he is reportedly working regular duty.

The Chiropractic Pre Authorization Letter of Reconsideration dated September 20, 2011 notes that the injured worker demonstrated strong lumbar paraspinal muscle spasms, restricted movements, antalgic stance, and difficulty walking after moving a set of outside stairs on September 11, 2011. Diagnosis was Lumbar IVD without myelopathy.

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

It appears that the injured worker sustained a separate injury to his lumbar spine on xx/xx/xx, superimposed upon the prior industrial injury of xxxx. It is incidentally



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

noted that the injured worker's current symptoms appear to be more closely related to a new, distinct injury rather than the prior industrial injury of xxxx.

It is unclear, moreover, how much physical therapy the injured worker has had to date. The guidelines do support fairly extensive treatment for postoperative lumbar spine issues. However, the current request for therapy is unaccompanied by documentation of the prior response to therapy and goals of further therapy.

The request for therapy, moreover, is for passive modalities consisting of electrical stimulation, ultrasound, and massage. At this point in time, passive modalities are not appropriate.

The injured worker should be progressing toward an independent home exercise program, at this point in time, some 9 years removed from the industrial injury.

For these reasons, the request is non-certified.

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