



7331 Carta Valley Drive | Dallas, Texas 75248 | Phone: 214 732 9359

## Notice of Independent Review Decision

**DATE OF REVIEW:** 12/22/10

**IRO CASE #:**

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

Additional Physical Therapy Lumbar 3xwk x4wks  
Neuromuscular Re-education Lumbar 3xwk x4wks  
Manual Therapy Lumbar 3xwk x4wks  
Therapeutic Activities Lumbar 3xwk x4wks

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

The reviewer is a board certified MD in Occupational 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.



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

Office visit notes, letters of medical necessity, imaging, physical examination and physical therapy evaluations.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a male who sustained a work injury on xx/xx/xx while, fell in a hole, landing on his knees. His initial diagnoses were a left ankle sprain, right knee sprain and lumbar radiculitis. He was seen by chiropractor who recommended physical therapy for injured body parts. He initiated Physical therapy and was placed on light duty. The patient has 2 prior lumbar spine injuries.

No medical records available for review for 10 years. The patient was evaluated by Dr. and Lumbar X rays and MRI were ordered on 10/14/10. MRI findings include multilevel lumbar facet arthropathy, anterolisthesis L5-S1 and L4-5. The patient received a impairment rating of 5% prior to his office visit with Dr.. Diagnoses include lumbar radiculopathy, lumbar disc herniation, low back pain and chronic low back pain. Dr recommends physical therapy modalities of therapeutic activities/exercise, neuromuscular education and manual therapy 3x week for 4 weeks.

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

Per ODG guidelines there is strong evidence that physical therapy has the best long term outcome with patients with low back pain with evidence of active therapy and not extensive use of passive modalities, however in this case, additional supervised physical therapy is not recommended.

This decision is based on the following findings:

There are no medical records to document that his ongoing symptoms are related to his occupational injury xx years ago.

Medical records reviewed stated that he received physical therapy in 2001 supervised by Dr and several sessions on 10/22, 10/28, 11/3 and 11/17/10 with lower back condition unchanged.



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At this point, xx years after his alleged injury, there is no indication that the patient will benefit from additional supervised physical therapy program that a self directed or home exercise program cannot offer.

**REFERENCES**

ODG GUIDELINES/PHYSICAL THERAPY FOR DISC INJURIES.

**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



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- 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)**