



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

Notice of Independent Review Decision

**DATE OF REVIEW:** 11/03/2011

**IRO CASE #:**

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

ADDITIONAL 6 PHYSICAL THERAPY SESSIONS OF THE LUMBAR AND THORACIC SPINE.

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

M.D. Board Certified in Physical Medicine and Rehabilitation with Expertise in Pain Management, Wound Management and Geriatrics.

**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**

<b>Document Type</b>	<b>Date(s) - Month/Day/Year</b>
Notice of Case Assignment	10/14/2011
Adverse Determination Letter	10/13/2011
Letter to	10/19/2011



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Services Corporation Adverse Determination Notices	9/27/2011-10/03/2011
Clinic Office Visit Notes and Evaluations Pre-Authorization for Medical Services	7/29/2011-9/15/2011 8/04/2011
DC Prescription for Physical Therapy	8/04/2011
M.D. Initial Exam Note	8/23/2011
Notice of Disputed Issue(s) and Refusal to Pay	9/26/2011

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant has a date of birth of xx/xx/xx. He was working. After leaning on a stand that collapsed, he complained of low back pain and neck pain. He did receive therapy. The therapy notes are not available to determine if there was progress or change in his functional condition with therapy. I reviewed the notes from the attending physicians which describe decreased range of motion of the spine – both cervical and lumbar and well as subjective low back and neck pain. There are no objective findings, no review of the therapy notes to determine benefit, and no follow up physical examination. There is no job description to determine what his work restrictions or needs would be on return. The request is for additional therapy to his thoracic and lumbar spine.

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

The ODG does recommend physical therapy for sprains and strains of the lumbar spine. Therapy for this patient was initially given. Following the therapy there should be documentation provided that shows functional change and improvement. ODG does require that therapy be shown effective before approving additional therapy. Exercise has been shown beneficial in back pain. However the need for supervision in exercise/therapy is not established. There should be physician follow up of the physical therapy notes to determine benefit and to order appropriate therapy individual to the patient’s condition. The current range of motion and function of this patient’s lumbar and thoracic spine is not addressed in the notes provided.

**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



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- 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