



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

Notice of Independent Review Decision

DATE OF REVIEW: 11/04/2012

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 Physical therapy to complete by 11/26/2012

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 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	10/15/2012
Preauthorization Determinations	9/11/2012-9/17/2012
Note	9/07/2012
Office Visit Notes	9/17/2012
Note	4/09/2012-10/04/2012
Physical Therapy Initial Evaluation	9/05/2012
Physician's Contract Services Note	9/04/2012
	8/22/2012



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Lumbar MRI Report	
MRI Report	4/03/2012
EMG and Nerve Conducting Report	10/01/2012
Clinical Note	9/06/2012
Initial Evaluation	5/01/2012
Pre-Authorization Request	3/19/2012

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a male who was injured on xx/xx/xx. He complained of sudden back pain. He was diagnosed with a lumbar strain without radiculopathy. MRI shows sacralization/transitional vertebrae. The reviewing physician indicates this patient had PT without any benefit; however, only a PT initial evaluation was provided. He did have an ESI on 6/20/12 with 40% relief which is not a successful ESI. On examination, there is 30 degrees flexion, 15 degrees extension and 20 degrees side bending of the lumbar spine.

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

Per ODG references, 12 physical therapy sessions are not medically necessary. However, per ODG references, 10 visits of physical therapy are recommended and medically necessary.

The ODG recommends 10 visits of physical therapy for a diagnosis of lumbar sprain/strain. There are no physical therapy notes included with this review. There was a physical therapy initial evaluation showing limitation of lumbar range of motion and continued pain.



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**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 KNOWLEDGE BASE
- 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