

IRO Reviewer Report

DATE OF REVIEW: 03/25/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Office visits for date 12/04/06

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

Board certified in anesthesia/pain management and on the TDI-WC approved doctor's list that is familiar with the treatment or proposed treatment.

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.

It is determined that the office visits for 12/04/06 was not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Information provided by the requestor:

- Letter from - 02/13/07
- Notice of Assignment of IRO - 03/12/07
- Report of Medical Evaluation - 12/20/05
- Review of Medical History & Physical Exam – 12/15/05
- Report of Medical Evaluation – 07/06/05
- Review of Medical History & Physical Exam – 06/30/05
- Comp Notes – 05/16/05 to 11/29/05
- Physical Therapy Initial Evaluation – 05/31/05
- Office notes from Dr. – 06/01/05
- Letter from Dr. – 06/03/05, 06/30/05
- Physical Therapy Re-evaluation – 06/09/05
- Letter from – 06/13/05
- Physical Therapy Progress Notes – 06/13/05
- Medical Record Review by Dr – 06/20/05
- Radiology reports, chest x-ray, right humerus x-ray, CT head – 06/23/05
- Report of MRI of the lumbar spine 05/25/05

Information provided by the respondent:

- Letter from attorneys with outline of enclosed information – 03/16/07
- Comp Notes – 05/16/05 to 04/24/06
- Report of MRI of the lumbar spine 05/25/05
- Physical Therapy Initial Evaluation – 05/31/05
- Office notes from Dr. – 06/01/05 to 11/14/05
- Physical Therapy Re-evaluation – 06/09/05
- Letter from Co. – 06/09/05
- Physical Therapy Progress Notes – 06/13/05
- Medical Record Review by Dr – 06/20/05
- Report of Medical Evaluation – 07/06/05, 12/20/05
- Decision letter - 07/09/05
- Office notes Dr. – 12/15/05
- Office notes Dr. – 01/04/06 to 12/04/06
- Operative note by Dr. – 02/23/06
- Independent Medical Evaluation – 08/22/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury when he strained his back while lifting a door from storage onto a delivery truck. The patient was diagnosed with lumbar strain injury and has been treated with medication, physical therapy, and epidural steroid injections.

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

This patient suffered a lumbar strain injury on xx/xx/xx. This should have resolved with epidural steroid injections and physical therapy provided to him. In addition, the medical record does not substantiate the necessity for medications in view of negative examination findings and the patient was advised to wean from medications on 08/22/06.

Given that the patient's injury was a lumbar strain, his unresponsiveness to treatments and the recommendation to wean pain medication, the record does not substantiate the necessity for the 12/04/06 office visit as the patient should have already been released.

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 KNOWLEDGBASE
- 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)