

# P-IRO Inc.

An Independent Review Organization

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**DATE OF REVIEW:** 5-15-07

**IRO CASE #:**

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

Twelve sessions of lumbar postoperative physical therapy

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

Board Certified, American Board of Physical Medicine and Rehabilitation

## **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**

Case Assignment from TDI, Correspondence from the URA including medical records and denial letters from the URA and Dr., Medical Records with the dates January thru April 2007 and May thru November 2006 including peer reviews, treating doctor's notes, consulting orthopedist notes, functional capacity evaluation, op report. Records from Dr. June 06 thru December 06, Functional Abilities Exams 8/21/06 and 10/23/06, and Hospital 11/25/06 and 12/25/06.

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

The claimant had a hyperextension lumbar injury. He underwent conservative therapy without adequate improvement. Ultimately he had surgical intervention which was followed with 24 sessions of physical therapy, concluding with transition to a home program. His pain had steadily decreased from around a 9/10 at the beginning of PT to about a 4/10 at its conclusion.

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

The claimant had adequate postoperative physical therapy to reduce his pain and improve his functional mobility. He reported worsening of his pain after having been on his home program although it is unlikely that this consisted of any significantly different exercises or biomechanics than had been used in his postop PT. This claimant has had adequate physical therapy following his operation which was over a year ago and does not have a reasonable indication for additional PT at this time.

**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 (PROVIDE A DESCRIPTION)