

SENT VIA EMAIL OR FAX ON
Mar/24/2009

IRO Express Inc.

An Independent Review Organization

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DATE OF REVIEW:

Mar/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 3 X 4 lumbosacral

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

Board Certified Orthopedic Surgeon

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

OD Guidelines

Office notes, Dr. 08/27/08, 09/17/08, 12/16/08, 01/06/09, 02/04/09

MRI lumbar spine, 12/30/08

PT initial evaluation, 01/14/09

PT notes, 01/22/09, 01/26/09, 01/30/09, 02/06/09, 02/10/09, 02/12/09
, 02/19/09, 02/27/09

Letter, Attorney, 03/09/09

Progress Note 08/26/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male injured on xx/xx/xx when he was lifting a box.

He was seen on 08/27/08 by Dr. It was reported that the claimant had x-rays that showed degenerative changes of the lower lumbar spine. On examination he was tender but had no neurological deficit. He was given anti-inflammatory medication and returned to work.

On 12/16/08 Dr. noted the claimant had pain with walking or standing that radiated to the right groin. The 12/30/08 MRI of the lumbar spine showed an L1-2 small right herniation with an annular tear indenting the thecal sac. There was L2-3 mild stenosis. At L3-4 was a mild disc bulge with moderate right herniation, mild bilateral facet arthrosis, mild canal stenosis and

mild to moderate left and moderate to severe right foraminal stenosis. There was an L4-5 disc bulge, mild bilateral facet arthrosis and mild to moderate foraminal narrowing. L5-S1 demonstrated mild disc bulge and mild bilateral facet narrowing. Therapy was ordered.

Therapy was initiated on 01/14/09. By 01/22/09 the inguinal pain was relieved and back pain was 1/10.

On 02/04/09 Dr. documented the claimant had variable response to therapy. Modalities and traction helped but exercises caused regression. Additional therapy was recommended.

The therapy note dated 02/12/09 indicated the claimant had no pain and only mild tenderness of the piriformis was noted.

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

This is a xx/xx/xx male with low back pain and no neurological deficits. He was last noted on 02/19/089 to be pain free. He had not been using traction prior to that visit, describing that he had no pain. In the absence of pain, functional limitations, structural abnormality or protective spasm, there is no apparent need for additional formal physical therapy. In addition, Dr. noted that the claimant's response to therapy had been variable. The true amount of therapy that has been provided was not apparent in these records and ODG would recommended ten sessions as medical treatment for a patient with back pain and stenosis. The request would clearly exceed recommendations. The claimant should be capable of performing a home exercise program of equal benefit at this point recommended by the ODG. The need for 12 physical therapy visits has not been established in review of the medical records provided.

Official Disability Guidelines Treatment in Worker's Comp 2009, Low Back-Physical therapy (PT)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)