

SENT VIA EMAIL OR FAX ON
Feb/24/2010

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 12 sessions

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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
Denial Letters 12/28/10 and 1/12/10
Pain & Recovery 8/31/09 thru 2/8/10
Dr. 6/29/09 thru 10/28/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured on xx/xx/xx (although Dr. wrote 4/30/09 and commented about his 4/24/09 MRI) lifting boxes. He did not attend therapy in June when approved. He had 12 sessions in August and September, but did not have any improvement of his pain or improved motion. He had not had recent therapy.

He has bilateral L5/S1 foraminal stenosis with an L5/S1 disc protrusion reaching bot L5 nerve roots. His examination showed local tenderness and reduced motion, but there was no neurological loss.

Dr. noted that this man had not plateaued and needed additional therapies. His progress note stated that a pain program had been requested.

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

The reviewer is not clear of the diagnosis. He may have a radiculopathy, but there was no

MRI report to review, and the neurological exam was normal. He would not have reached the requirements of a radiculopathy per the ODG, which in turn relies on the AMA Guides. He is now 11 months post injury. The reviewer is not clear why the therapy would need to be resumed if it had not helped. The ODG permits up to 10 visits with a disc problem and the patient was to be involved in a self directed program. The reviewer did not see where such a program occurred. Further, the reviewer does not see an explanation why this man needs the additional treatments other than he has "not plateaued." What activities did he perform from at least the 10/09 visit and the 12/16/09 therapy note? Were there complications, etc to preclude progress? Without this information, the reviewer's medical assessment is the request is not medically necessary.

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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