

SENT VIA EMAIL OR FAX ON
Mar/16/2011

IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/16/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT lumbar 3 X 3

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

Board Certified PMR and Pain Management

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

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male. The patient was when he twisted and felt a popping sensation. He began having lower back pain with left sided buttock and leg pain. Treatment to date is noted to include lumbar MRI, epidural steroid injection x 3, which helped for 1-2 weeks, multiple spinal decompression traction procedures with a chiropractor with no lasting improvement, and medication management. Lumbar MRI dated 03/30/09 reportedly revealed decreased signal intensity at L4-5, L5-S1 levels with HNP, left sided paracentral L4-5 HNP with L5 root compression. Clinical impression is L4-5 HNP with radiculopathy. The patient was recommended for outpatient decompression at the L4-5 level.

The patient underwent microendoscopic left L4-5 hemilaminectomy, medial facetectomy with L5 foraminotomy, subarticular decompression and partial inferior L3-4 facetectomy and L4 foraminotomy on 07/20/09. Follow up note dated 08/04/09 indicates that the patient was recommended to undergo four weeks of outpatient physical therapy.

Follow up note dated 10/20/09 indicates that the patient was doing reasonably well, but recently felt a twinge in his back when getting up and off of a mattress and was seen in the emergency room. The patient was placed on Zanaflex and Medrol DosePak. Follow up note dated 01/19/10 indicates the patient underwent a recent lumbar MRI which revealed postoperative changes at L4-5 with decreased signal intensity and a somewhat moderate broad-based left paracentral HNP with some moderate foraminal narrowing. The patient was recommended for 3 weeks of physical therapy.

Follow up note dated 03/23/10 indicates that the patient underwent an epidural steroid injection which helped 40% and he is scheduled for a second injection. Follow up note dated 05/04/10 indicates that the patient underwent second injection and feels 75-80% better. Follow up note dated 08/20/10 indicates that EMG/NCV studies are consistent with lumbar radiculopathy at L4-5. The patient was recommended for four-week physical therapy program with the possibility of admittance to a work hardening program.

Initial request for physical therapy was non-certified on 01/24/11 noting that the request is excessive, as the Official Disability Guidelines support only 6 sessions for chronic pain exacerbation, and contact was not made with the requesting provider to modify the request. The denial was upheld on appeal dated 02/10/11 noting that the requested number of sessions exceeds the ODG recommendations. There are no recent provider notes to define what the claimant is suffering from other than a presumption that he is a failed back with radiculitis.

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

Based on the clinical information provided, the request for PT lumbar 3 x 3 is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent surgical intervention to the lumbar spine on 07/20/09; however, there is no comprehensive assessment of postoperative treatment completed to date or the patient's response thereto submitted for review. The patient is noted to have undergone two epidural steroid injections postoperatively, but it is unclear how many sessions of physical therapy the patient completed, and the patient's objective, functional response to PT is not documented. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals are provided. Given the current clinical data, the requested physical therapy lumbar 3 x 3 is not indicated as medically necessary, and the two previous denials are upheld.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES