

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Pain & Recovery Clinic – North 6660 Airline Drive Houston TX 77076	MDR Tracking No.: M5-05-2548-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Rep Box # 19 Fidelity & Guaranty Ins c/o FOL	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
9-3-04	10-27-04	99212, 97110, 97140, 97112, 97032	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 6-22-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

On 9-15-04 requestor billed codes 99212, 97110, 97140, and 97112. Neither party submitted an EOB. Requested submitted convincing evidence of request for EOB. Therefore, these services will be reviewed per the 2002 MFG. Recommend reimbursement as follows:

- 99212 = \$38.42 x 125% = \$48.03
- 97140 = \$27.13 x 125% = \$33.90 x 2 units = \$67.80
- 97112 = \$36.69 (as billed which is less than MAR)

- 97110 = **RATIONALE:** Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because no documentation was submitted to clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement of \$152.52 for the fee issues involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Authorized Signature

Typed Name

8-26-05

Date

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative’s box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County (see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

IRO America Inc.

An Independent Review Organization

(IRO America Inc. was formerly known as ZRC Services Inc. DBA ZiroC)

7626 Parkview Circle

Austin, TX 78731

Phone: 512-346-5040

Fax: 512-692-2924

August 23, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TWCC #:

MDR Tracking #:

IRO #:

M5-05-2548-01

5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission (TWCC) has assigned this case to IRO America for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic care. The reviewer is on the TWCC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by Requestor, Respondent, and Treating Doctor(s) including:

1. Medical Dispute Resolution Request.
2. Table of Disputed Services, 9-3-04 through 10-27-04.
3. TWCC-62s, 9-3-04 through 10-27-04.
4. Documentation from Northeast Medical Center Hospital, 11-5-03.
5. Lumbar x-ray report, 11-5-03.
6. Medical records from U.S. Healthworks, 11-7-03 through 3-3-04.
7. Lumbar MRI report, 12-2-03.
8. Medical records from the Pain and Recovery Clinic of North Houston, 3-25-04 through 1-17-05.
9. IME from Donald Nowlin, M.D., 3-12-04.
10. Request to Change Treating Doctors, 4-1-04.
11. Electrodiagnostic report, 4-16-04.
12. Medical report from Will Moorehead, M.D., 4-20-04.
13. Medical reports from Ali Mohamed, M.D., 5-20-04 through 9-9-04.
14. DD Evaluation from Muntaz Ali, M.D., 5-25-04.
15. Operative Reports, 6-23-04, 7-15-04, and 8-12-04.
16. Electrodiagnostic report, 8-5-04.
17. Retrospective Peer Review from K.L. Blanchette, M.D., 8-9-04.
18. FCE, 8-18-04.

19. Daily Progress Notes from the Pain and Recovery Clinic, 9-3-04 through 10-26-04.
20. Operative report, 9-22-04.
21. Work Hardening Assessment Psychosocial History, 9-30-04.
22. Medical report from Mark McDonnell, M.D., 10-1-04.
23. FCE, 10-15-04.
24. Request for Work Hardening, 10-20-04.
25. Impairment Rating from Nestor Martinez, D.C., 2-1-05.
26. Functional Capacity Assessment, 2-1-05.
27. Statement of Medical Necessity from the Pain and Recovery Clinic, 3-18-05.
28. Letter from Flahive, Ogden & Latson, 6-29-05.
29. Submission of the Documents to the IRO from the Pain and Recovery Clinic, 7-13-05.

CLINICAL HISTORY

The patient was working as a Housekeeper for the _____ when she reported a low back injury after lifting a mattress. The patient presented to the Northeast Medical Center Hospital reporting axial low back pain. Lumbar x-rays were unremarkable. Lumbar range of motion was restricted and muscle spasms were elicited with palpation. Neurologically the patient was intact and nerve root tension signs were absent. The patient was diagnosed with a lumbar strain and released with a prescription for Vicodin and instructions on over-the-counter Motrin and Tylenol.

The patient was evaluated by Dr. Rosenkrantz at the U.S. Healthworks Clinic on 11-7-03. The patient again only reported axial low back pain. She was diagnosed with a lumbar sprain/strain. She was taken off work for an additional four days and referred for physical therapy. The patient participated in approximately 6 weeks of physical therapy. On 11-11-03, the patient was returned to work with restrictions. Restrictions were gradually lifted through 2-17-04. On 11-26-03, Dr. Rosenkrantz classified the patient as a symptom magnifier. He felt the patient's subjective complaints of pain were out of proportion to her physical exam findings. He also reported multiple Waddell signs.

Lumbar MRI dated 12-2-03 demonstrated disc degeneration with normal appearing interspaces at L3-4, L4-5, and L5-S1. There was a "shallow" broad-based midline disc herniation at L4-L5 without evidence of neural foramen compromise.

On _____, > 4 months status post injury, the patient was evaluated by Donald Nowlin, M.D. Again, the patient only reported axial low back pain. The patient appeared comfortable during the history and arose for the physical examination without hesitation or support. Right SLR was 40° and left SLR 20°; however, seated SLR was 90° bilaterally (Waddell sign). Heel and toe walk were normal. She could one-half squat. Regional disturbances and overreaction were also inappropriate (Waddell signs). We now have two independent providers reporting Waddell signs. Diagnosis was a resolved lumbar sprain/strain. He felt the patient could work with restrictions. He also felt the patient did not require any further in-office chiropractic/physical therapy treatment. Lastly, he felt the patient could be performing a self-directed home program.

Please note every provider prior to this date documented only axial low back pain without lower extremity symptoms. Additionally, Waddell signs were clearly noted.

On 3-25-04, the patient was evaluated by Dean McMillan, M.D. at the Pain and Recovery Clinic. The patient was working light duty at the time of this evaluation. The patient reported ongoing low back pain aggravated by bending, squatting, lifting, standing, and walking. Physical examination revealed tenderness in the lumbar spine, muscle guarding, restricted range motion, and positive Kemp's and Lasegues. Despite the fact the patient only "reported" low back pain to Dr. McMillan; surprisingly, Dr. McMillan diagnosed the patient with a lumbar radiculitis. The patient was now 4 1/2 months status post injury (chronic pain as defined by Quebec, Frymoyer, Mayer & Gatchel, NASS, AHCPR, and the ODG). Shockingly, Dr. McMillan recommended passive therapeutic modalities. Dr. McMillan prescribed Bextra and the patient was instructed to continue working modified duty.

On 4-1-04, the patient requested a change of treating doctors to Dr. McMillan.

On 4-8-05, Dr. McMillan recommended electrodiagnostic testing. Not surprisingly, since the patient reported no lower extremity symptoms, the electrodiagnostic testing was completely unremarkable.

On 4-20-04, an orthopedic evaluation was performed by Dr. Moorehead. Again, the patient reported only axial low back pain provoked with bending, lifting, and sitting. The patient specifically reported no radiating lower extremity pain, numbness, or tingling. Physical examination revealed no weakness, no muscle spasms, no trunk shift, no posterior thigh tenderness, and no SI joint tenderness. Lumbar flexion was 80°, extension 20°, left lateral flexion 28°, and right lateral flexion 26°. He recommended McKenzie exercises and trunk stabilization exercises. He certainly did not mention the need for ongoing supervised rehab for 6 months.

The patient continued physical therapy at the Pain and Recovery Clinic. To my knowledge, none the chiropractors or therapist at this clinic are certified in McKenzie; despite this, rehab continued at the P&RC at a frequency of three times per week. The documentation dated 4-21-04, after the evaluation from the Dr. Moorehead, reported ongoing performance of the exact same exercise program. Furthermore, the McKenzie exercises were never performed or at least documented.

Re-evaluation with Dr. McMillan dated 5-18-04 reported only "temporary relief" with the medication and physical therapy; however, the pain persists. Physical examination was unchanged. He recommended continuation of physical therapy at a frequency of three times per week. The patient was prescribed Celebrex and Flexeril and now Ultram was added.

On 5-20-04, the patient was evaluated by Ali Mohamed, M.D. He recommended a series of epidural steroid injections.

The documentation from Dr. McMillan dated 6-17-04 reported the patient "has not experienced improvement or resolution of signs and symptoms" with the therapy provided. Contradictory to this statement, his impression mentioned the patient "overall, responded fair to therapy." Physical examination was completely unchanged. Again, he recommended additional physical therapy.

On 6-23-04, the patient was taken out of work completely. On 6-29-04, Dr. McMillan reports persistent severe low back pain radiating into the lower extremities increased with working, standing, sitting, bending, and squatting. His clinical impression was "failed conservative treatment including medications, and passive and active therapy."

On 5-24-05, a Designated Doctor Evaluation was performed by Dr. Ali. The patient reported low back pain, right hip pain, and left hip pain rated 8/10. Symptoms were consistent in nature with sitting, sleeping, pushing, pulling, and bending. Distracted SLR test was positive (Waddell sign). Range of motion testing was decreased with sub-maximal effort. Sub-maximal effort was given with heel and toe walk. The patient was found to have reached maximum medical improvement on 5-25-04 and assigned 5% WPI.

On 6-23-04, the first epidural steroid injection was performed. Post injection physical therapy was continued. On 7-15-04, the second epidural steroid injection was performed. The patient reported some improvement and gave a numerical pain scale of 6/10.

Physical therapy documentation from the Pain and Recovery Clinic mentioned low back pain ranging between 3/10 and 8/10. Trunk rotation was within normal limits. Lumbar extension appears to have been normal. Lumbar flexion was only restricted by 10%. The exact same exercise program was implemented.

On 8-4-04, Dr. McMillan now documented behavioral issues such as insomnia and depression. Physical examination was virtually unchanged. Patient was prescribed Ultracet, Celebrex, and now even Zoloft. Not surprisingly, re-peat electrodiagnostic testing on 8-5-04 was unremarkable.

A retrospective peer review was performed on 8-9-04. He felt the patient suffered a sprain/strain injury. He recommended discontinuation of prescription medications.

On 8-12-04, a third epidural steroid injection was performed. Post injection, the patient reported a numerical pain scale of 5-6/10. Therapy continued at the Pain and Recovery Clinic. Due to ongoing low back pain, a pain management referral was recommended on 8-31-04. The patient was still not working.

FCE 8-18-04:

Torso lift 37.7 pounds, pull 36.3 pounds, push 29.6 pounds, arm lift 43.1 pounds, high near lift 35.8 pounds, floor to shoulder frequent 21 pounds, maximum left grip 63.2 pounds, and maximum right grip 63.8 pounds. The floor lift was not valid; therefore, irrelevant. Given the nature of the injury (lumbar), it is not practical for the patient's torso lift (predominately lumbar and hamstring strength) to be > the floor lift (predominately quad/leg and hip strength).

The physical therapy documentation from the Pain and Recovery Clinic dated 9-3-04 through 10-26-04 demonstrated the billing of five units of active based therapy, two units of manual procedures, moist heat pack, and electrical stimulation. Shockingly, the program was never progressed. In other words, the patient performed the exact same exercise program over and over again from 9-3-04 through 10-26-04. Even the number of sets and reps remained the same.

Due to ongoing low back pain, lumbar facet joint injections were performed on 9-22-04. Dr. McMillan documents continued pain and discomfort in the lumbar spine despite this injection. He reports ongoing radicular signs and symptoms as well as SI joint manifestation on physical examination. Again, he recommended continued physical therapy, continuation of the same medication, and an orthopedic spine surgical evaluation.

On 9-30-04, a psychosocial history was performed. The McGill Pain questionnaire demonstrated constant, throbbing, sharp, and tingling low back pain. Pain Inventory/Short Form reported a pain scale of 7/10. Symptoms interfered with general

activity (8), mood (7), walking (7), work (7), sleep (9), and enjoyment of life (7). Oswestry was 34%. The LPC recommended a Work Hardening Program.

On 10-1-04, the patient was evaluated by Mark McDonnell, M.D. He reported constant low back pain rated 7/10-9/10. The report specifically indicated all previous treatment including chiropractic, exercise, passive modalities, epidural steroid injections, and facet injections provided "no relief." Dr. McDonald impression was axial back pain syndrome "failing all non-operative care." He recommended fusion versus disc replacement versus IDET.

FCE 10-15-04:

Torso lift 28.4 pounds, pull 26.1 pounds, push 27.6 pounds, arm lift 29.7 pounds, high near lift 26.5 pounds, floor to shoulder frequent 21 pounds, maximum left grip 50.9 pounds, and maximum right grip 54.1 pounds.

Due to ongoing low back pain and disability, a Work Hardening Program was performed after the services being reviewed. A Mental Health Evaluation dated 12-6-04 (again, after the services being reviewed) the patient reported a numerical pain scale of 9/10. Dallas Pain Questionnaire was 107/150 (severe) and PAIRS was 83/105 (disabled). Due to a poor response with the four-week Work Hardening Program, a CPMP was performed. Again, all of this is following the treatment being reviewed (9-4-04 through 10-27-04).

On 12-31-04, the patient reported a numerical pain scale of 7/10. Dr. McMillan prescribed Celebrex and Zolofl and now Motrin, Ultram, and Phenergan.

On 2-1-05, Dr. Nester Martinez performed an impairment rating. The patient reported ongoing low back pain with pain radiating into the posterior thighs bilaterally. Symptoms were aggravated with standing, sitting, bending, squatting, and lifting (identical to the initial evaluation in March of 2004). The patient was not working. Please recall, the patient was working for 7 months after the injury. Range of motion was restricted in flexion, extension, and rotation. All movements elicited low back pain. SLR on the left reproduced left posterior thigh pain. Kemp's test still elicited low back pain. There was diminished sensation in the left lower extremity in the S1 dermatome. The patient was assigned 5% WPI.

On 3-18-05, a Request for Reconsideration was performed for services performed between 9-3-04 and 10-27-04.

DISPUTED SERVICE(S)

Under dispute is the retrospective medical necessity of E&M (99212), therapeutic exercise (97110), manual therapy techniques (97140), neuromuscular reeducation (97112), and electrical stimulation-manual (97032). Dates of service disputed include 9-3-04 through 10-27-04.

DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

First and foremost, after revealing all the documentation supplied, not just the documentation from the Pain and Recovery Clinic, the story clearly demonstrates a patient who actually deteriorated in many regards from March of 2004 through 10-27-04 despite an excessive and unsuccessful attempt to control pain, objectively promote recovery, reduce the need for health-care services, create independence, and return the patient to gainful employment.

The billing of an E&M code on each visit is not reasonable or necessary > 10 months status post injury.

Based on the available records provided, the patient sustained a lumbar sprain-strain and possibly an aggravation of a pre-existing degenerative disc. The advanced imaging findings and the electrodiagnostic findings do not support the diagnoses of a lumbar radiculopathy or nerve root impingement. Additionally, we do not have inter-tester consistency of positive nerve root tension signs or even inter-tester consistency of lower extremity symptoms for that matter. Therefore, we essentially have a sprain/strain injury complicated by a preexisting degenerative disc.

It is well-documented in the medical literature that lumbar sprain/strain injuries typically require 6-8 weeks of chiropractic/physical therapy treatment. With underlying delayed recovery factors such as degenerative disc disease, the patient may require a more protracted course of care. This may certainly extend the need for in-office treatment.

Early on in the course of treatment, there was strong evidence of symptom magnification in the form of Waddell signs and pain behaviors. When these factors exist, the treatment plan should be altered to deemphasize passive care and focus on active based exercise and what the patient is capable of doing (function). The patient presented to the Pain and Recovery Clinic on 3-25-04, after 4 1/2 months of pain. Shockingly, passive care was included in the treatment plan and continued from 3-25-04 through 10-27-04, for a total of seven months. The treatment performed between 9-3-04 and 10-27-04 included manual therapy techniques,

moist heat, and manual electrical stimulation. The reviewer believes at this treatment was not only unnecessary but contraindicated. There is insufficient medical evidence to support ongoing use of passive care in the treatment of chronic low back pain. In fact, there is good evidence of no clinically important benefit with the use of such passive procedures. The Philadelphia Panel of Physical Therapy found insufficient evidence to support electrical stimulation and manual procedures in the treatment of chronic back pain when looking at relevant clinical outcomes such as pain, functional status, and/or patient global assessment. The reviewer believes this is completely unacceptable. Dr. McMillan should know that passive modalities have no place in the treatment of chronic low back pain greater than 8-12 weeks and certainly have no place in the treatment of back pain greater than 4 1/2 months. For this reason, the manual procedures and manual electrical stimulation should be time limited. These procedures between 9-3-04 and 10-27-04 were neither reasonable nor necessary to treat the compensable injury.

The documentation fails to demonstrate the treatment performed between 9-3-04 and 10-27-04 reduced the need for additional health-care services. The documentation clearly indicates the patient's need for prescription medication increased despite treatment. Additionally, despite the treatment performed, the patient participated in a Work Hardening Program and a Chronic Pain Management Program due to ongoing complaints of pain and disability following the treatment for review. The reviewer believes that this clearly demonstrates insignificant improvement between 9-3-04 and 10-27-04 despite the course of care.

The documentation provided fails to indicate the treatment enhanced the ability of the patient to return to work. The patient was working modify duty for 4 1/2 months prior to being evaluated at the Pain and Recovery Clinic. Additionally, the patient was working modify duty initially while receiving treatment at the Pain and Recovery Clinic. Despite the excessive in office treatment, the patient was taken off work completely. Even the impairment rating performed in February of 2005 indicated the patient was incapable of working. The reviewer believes the treatment performed did not enhance the ability of this patient to return to gainful employment.

The documentation fails to indicate the treatment at the Pain and Recovery Clinic improved the patient at a faster rate than the natural history. The natural history serves as a timeframe for gauging the overall success of the treatment strategy. As of 10-27-04, the patient was 11 months status post injury and had already received 9 months of chiropractic/physical therapy treatment. I would expect a faster and more complete recovery with appropriate treatment when compared to the natural history.

The reviewer believes the therapeutic exercise and neuromuscular reeducation performed between 9-3-04 and 10-27-04 was not reasonable or necessary to treat the effects of the injury. After a close review of the exercise logs, the documentation does not support one-on-one based exercise at this stage of recovery. The documentation clearly indicates the exercise program was never progress. In fact, the Pain and Recovery Clinic billed one-on-one therapeutic exercise at an intensity of five units for existing exercises. Again, the patient's program did not change at all. The reviewer believes the patient does not require one-on-one supervision to perform a well-established exercise program. Surprisingly, the exercise program in July of 2004 was identical to the exercise program performed September and October of 2004. At what point should a patient be independent with a program and not require one-on-one supervision to perform the same program over and over again? In the Reviewer's medical opinion, once a home program is successfully established, one-on-one supervision is no longer indicated. This opinion is supported by a 1999 Volvo award study by Mannion et al. The subjects were placed in a rehabilitation program for 24 visits and instructed to continue their programs independently at home. Improvements included pain intensity, pain frequency, disability, and fear-avoidance beliefs. These improvements were maintained over the subsequent six-months after discharge. My point is that after a patient has been adequately instructed in a home program; the patient should be discharged independent with this home exercise program and a home aerobic program. A home program is motivational, can be performed on a daily basis, and is certainly more cost effective than ongoing in-office treatment and supervision.

The treatment provided did not appear to have objectively promoted recovery. On 7-27-04, the Pain and Recovery Clinic documented normal lumbar rotation, unremarkable lumbar extension, and lumbar flexion only limited by 10%. The FCE dated 8-18-04 demonstrated a torso lift 37.7 pounds, pull 36.3 pounds, push 29.6 pounds, arm lift 43.1 pounds, high near lift 35.8 pounds, floor to shoulder frequent 21 pounds, maximum left grip 63.2 pounds, and maximum right grip 63.8 pounds. Additionally, the floor lift was not valid; therefore, irrelevant. Given the nature of the injury (lumbar), it is not sensible for the patient's torso lift to be > the floor lift. The FCE dated 10-15-04 demonstrated a torso lift 28.4 pounds, pull 26.1 pounds, push 27.6 pounds, arm lift 29.7 pounds, high near lift 26.5 pounds, floor to shoulder frequent 21 pounds, maximum left grip 50.9 pounds, and maximum right grip 54.1 pounds. It appears quit obvious that the treatment performed between 8-18-04 and 10-15-04 did not improve her functional status. Lastly, the IR dated 2-1-05 demonstrated ongoing low back pain with pain referral into the posterior thighs bilaterally. Symptoms were aggravated with standing, sitting, bending, squatting, and lifting. The patient was not working. Range of motion was restricted in flexion, extension, and rotation. All movements elicited low back pain. SLR on the left reproduced left posterior thigh pain. Kemp's test elicited low back pain. There was diminished sensation in the left lower extremity in the S1 dermatome. In other words, objective improvement has not been quantified by the documentation supplied. The reviewer believes this is insufficient evidence of improvement to support the treatment between 9-3-04 and 10-27-04.

Lastly, there is insufficient "inter-tester" documentation of subjective improvement to support the treatment provided. In fact, with the exception of the Pain and Recovery Clinic, there has been minimal subjective improvement as a result of the treatment in their office. For instance, the patient initially only reported axial low back pain to all the health-care providers involved in the case prior to March of 2004. After treatment in the Pain and Recovery Clinic, the patient reported lower extremity symptoms (peripheralization) demonstrating a deterioration in her subjective complaints. The IME dated 3-12-04 reports only axial low back pain. The orthopedic evaluation by Dr. Moorehead dated 4-20-04 reports only axial low back symptoms. In fact, the patient specifically denies lower extremity symptoms. He mentions no weakness, no muscle spasms, no posterior thighs symptoms, no posterior thigh tenderness, no SI joint tenderness, 80° of lumbar flexion, 20° and lumbar extension, 28° of left lateral flexion, and 26° of right lateral flexion. The documentation from Dr. McDonnell dated 10-1-04 clearly demonstrates a constant numerical pain scale ranging between 7/10 and 9/10. The patient specifically reported "no relief" despite conservative care and injection procedures. His impression was "severe axial back pain failing all non-operative care." The documentation from Michele Zamora, LPC dated 12-6-04, after the dates of service in request, demonstrated a DPDG of 9/10, DPQ 107/150, PAIRS 83/105, and GAF 60. Lastly, the documentation from Dr. Martínez dated 2-1-04 reported low back pain radiating into her posterior thighs bilaterally aggravated with standing, sitting, bending, squatting, and lifting. Lumbar flexion, extension, and rotation were restricted producing low back pain. Left SLR produced left posterior thigh pain. Kemp's was still positive. Sensory testing revealed a diminished sensation in the left S1 dermatome.

Essentially, if one reviews "all" the documentation from "all" the health-care providers involved in this case, there has been insufficient subjective improvement, objective improvement, or functional improvement as a result of the treatment between 9-3-04 and 10-27-04. Additionally, this treatment did not reduce the need for additional health-care services or enhance the ability of this patient to return to work. Over-treatment and over-utilization have been shown to commonly contribute to chronic pain, dependency, and even a disability mindset. In the Reviewer's medical opinion, the ongoing course of in office treatment likely contributed to dependency and likely fostered a disability mindset.

Screening Criteria

General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by TWCC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the TWCC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

IRO America Inc.



Dr. Roger Glenn Brown

President & Chief Resolutions Officer