

Prime 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-9015
Email: manager@prime400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/03/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3x/week x 4 weeks (12 visits)

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in 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

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 2/24/09, 3/2/09
MD, 3/3/09, 3/5/09
MRI Cervical Spine, 2/4/09
Dr. DC, 12/29/08, 1/12/09
MD, 3/3/09
Back and Neck Clinic, 3/3/09, 3/6/09, 12/12/08, 2/6/09
MRI Cervical Spine, 1/14/09
DO, 1/28/09
DO, 2/4/09, 12/17/08
12/9/08, 12/11/08, 12/12/08
MRI Right Knee, 1/14/09
MRI Lumbar Spine, 1/14/09
MRI Right Hip, 1/14/09
Rehab Request, 12/29/08

PATIENT CLINICAL HISTORY SUMMARY

This is a woman reportedly injured on xx/xx/xx when she slipped and fell on her right leg/knee and her back. She initially had back and leg pain, but subsequently had cervical pain. She was found to have reduced sensation at L3-5 on the right and C7-8 on the left. The cervical MRI done on 1/14/09 showed congenital cervical stenosis with multiple levels of degenerative changes including a disc extrusion and cord compression at C5/6 and lesser changes at C4/5 and C6/7. The lumbar MRI done on 1/14/09 showed degenerative spondylolithesis at L4/5 with disc bulges and foraminal stenosis at L3/4 and L5/S1 associated with degenerative changes. The 1/14/09 MRI of the right knee showed degenerative changes with chondromalacia and compartmental narrowing with osteophytes. An EMG on 2/6/09 showed evidence of a bilateral L4 radiculopathy, although the left tibialis was the only peripheral muscle involved. The EMG on 3/3/09 showed bilateral C5 radiculopathy with bilateral paraspinal and deltoid involvement. Dr. performing a Designated Doctor Examination felt the main problems were back strains, hip contusion and right knee sprain. She had physical therapy in December 2008.

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

The medical records in this case indicate the findings in the cervical and lumbar spine and knee are chronic. Her symptoms are acute. Dr. wrote on 12/29/08 "At this point we have initiated a course of treatment consisting of the application of physical medicine modalities and procedures." The current request is for 12 sessions of therapy. All of the recommended treatment programs in the ODG are for fewer than the 12 sessions requested. The patient had some therapy in December as noted, but the type and amount were not included. However, the treatment times recommended in ODG are for single joint problems and not the multiple joints as presented in this patient's case. In addition, the ODG states that "the publications are guidelines, not inflexible prescriptions and they should not be used as sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions...but they cannot take into account the uniqueness of each patient's clinical circumstances." In this patient's particular circumstance, the reviewer finds that these 12 additional noninvasive treatments are medically necessary, because they could avoid the need for cervical surgery in this patient. The reviewer finds that medical necessity exists for Physical Therapy 3x/week x 4 weeks (12 visits).

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)