

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy x 12 Sessions and EMG of RUE

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
Board Certified in Electrodiagnostic Medicine

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

This is a woman who was injured at work on xx/xx/xx. She reportedly had right shoulder pain after repetitive lifting of boxes. She was diagnosed with a shoulder strain and impingement. She improved with physical therapy in the summer of 2006. The therapist noted in the 9/18/06 report of improvement of shoulder pain and the intermittent numbness in the right arm. She apparently did well until May 2008 when she began to have recurrent shoulder pain and tingling and in her right arm and her right hand that wakened her at night. She had 9

sessions of physical therapy in the summer of 2008. The therapist reported she was discharged due to questions on payment. She was seen in December 2008 for additional physical therapy. Dr. wrote on 12/31/08 that the claimant required additional therapies and electrodiagnostic studies. No MRIs were reported of the cervical spine or shoulder.

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

The records indicate this patient had a recurrent strain or impingement. The ODG recognizes the need for physical therapy. It encourages a reduction in treatment targeting a self directed program. It allows for 10 therapy sessions over 8 weeks for treatment of rotator cuff injuries and impingement syndrome and shoulder strains. This patient has already had 9 sessions of physical therapy. The request exceeds the guidelines. There is no justification provided in the records for the 12 additional therapy sessions according to the ODG criteria. The patient does not meet the ODG criteria for EMG of RUE. The reviewer finds that medical necessity does not exist for Physical Therapy x 12 Sessions and EMG of RUE.

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)