

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:

Jan/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3xWk x 4Wks 97012 97112 97140 97035 97140 Lumbar (G0283 PNR)

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

M.D., Board Certified, Orthopedic 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

ODG Guidelines and Treatment Guidelines, Low Back – Lumbar & Thoracic

Adverse Determination Letters, 12/14/09, 12/21/09

Nursing Record 9/28/09

Imaging 10/7/09

D.O., Exam Notes, 10/14/09, 12/4/09

Sports Med 11/13/09, 11/18/09, 11/19/09, 11/20/09, 11/24/09, 11/25/09, 12/8/09, 12/9/09, 12/11/09

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a woman with a date of injury of xx/xx/xx. The initial ER evaluation notes the essentially normal physical examination, some tenderness to palpation and an assessment of a lumbar strain. Previous reviewer states that after completing 12 sessions of physical therapy, the injured employee was feeling better with decreased pain. Strength was noted as 5/5 and straight leg raising was negative. Previous reviewer notes that there was no clear rationale provided as to why additional physical therapy was needed. The reconsideration request noted improvement and then a regression in symptoms. An injection was performed. There are physical therapy progress notes noting pain in the 2/3 out of 10 levels. Some limitations were noted. The physical therapist requested additional PT sessions, and this was endorsed by the primary treating physician. MRI of the lumbar spine noted a L5-S1 disc in contact with the S1 nerve roots. There are several additional physical therapy assessments, however, there are no progress notes included from the treating

physician evaluating the changes noted on physical examination with the findings identified on MRI.

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

The lesion on MRI has not been addressed in the medical records provided for this review. The ODG guidelines for physical therapy for a lumbar spine injury with intervertebral disc disorder are 10 visits over 8 weeks. This physical therapy has already been completed by this patient. There is no objective and independently confirmable medical evidence presented in the records provided for this review that supports the request for additional physical therapy. The reviewer finds that medical necessity does not exist for Physical Therapy 3xWk x 4Wks 97012 97112 97140 97035 97140 Lumbar (G0283 PNR).

LUMBAR SPRAINS AND STRAINS (ICD9 847.2)

10 VISITS OVER 8 WEEKS

SPRAINS AND STRAINS OF UNSPECIFIED PARTS OF BACK (ICD9 847)

10 VISITS OVER 5 WEEKS

SPRAINS AND STRAINS OF SACROILIAC REGION (ICD9 846)

MEDICAL TREATMENT: 10 VISITS OVER 8 WEEKS

LUMBAGO; BACKACHE, UNSPECIFIED (ICD9 724.2; 724.5)

9 VISITS OVER 8 WEEKS

INTERVERTEBRAL DISC DISORDERS WITHOUT MYELOPATHY (ICD9 722.1; 722.2; 722.5; 722.6; 722.8)

MEDICAL TREATMENT: 10 VISITS OVER 8 WEEKS

POST-INJECTION TREATMENT: 1-2 VISITS OVER 1 WEEK

POST-SURGICAL TREATMENT (DISCECTOMY/LAMINECTOMY): 16 VISITS OVER 8 WEEKS

POST-SURGICAL TREATMENT (ARTHROPLASTY): 26 VISITS OVER 16 WEEKS

POST-SURGICAL TREATMENT (FUSION, AFTER GRAFT MATURITY): 34 VISITS OVER 16 WEEKS

INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY (ICD9 722.7)

MEDICAL TREATMENT: 10 VISITS OVER 8 WEEKS

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)