

Core 400 LLC

An Independent Review Organization

209 Finn St

Lakeway, TX 78734

Phone: (530) 554-4970

Fax: (530) 687-8368

Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 PT visits for Lumbar strain

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

M.D., board certified in 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 Physical Therapy Guidelines

Denial letters, 12/11/09, 12/22/09

xxxxxxx 11/30/09, 12/7/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who was injured on his job on xx/xx/xx. He had gradual onset of back pain. He was seen and evaluated and found to have a normal neurological examination and found to have some muscle spasm and sprain in his back. The diagnosis was lumbar strain. Recommendation was for conservative care with 12 visits of physical therapy.

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

The ODG Guidelines recommend a six-visit clinical trial for a lumbar sprain, followed in certain circumstances by ten visits over eight weeks. The prior reviewers agree that this patient meets guidelines for a six-visit clinical trial. This request for 12 sessions of physical therapy exceeds the number of trial PT sessions that are specified in the statutorily mandated guidelines. The requesting physician has not explained why the guidelines should not be followed in this claimant's case. The reviewer is unable to overturn the previous adverse determinations. The reviewer finds that medical necessity does not exist for 12 PT visits for

Lumbar strain.

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)