

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 - AMENDMENT -

DATE OF REVIEW:

Apr/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy, 4 visits for the lumbar spine

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

MD, Board certified in Physical Medicine and Rehabilitation

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

Denial letters, 3/17/10, 3/22/10

Injury Center 3/12/10, 1/22/10, 4/25/08, 3/4/09, 1/15/09

Diagnostics 6/18/09

MRI 5/15/08

9/29/06, 9/15/06

Consultant 3/12/10, 4/25/08

Surgery Center 6/29/09

Orthopedics 3/2/09

11/17/08

Orthopedic Group 6/26/08

MRIoA 3/17/10, 3/19/10

PATIENT CLINICAL HISTORY SUMMARY

This employee reportedly fell at work on xx/xx/xx. She has had complaints of mid to low back pain. There is a history of spinal fusion in 2000. On MRI there are post op changes at L4/5 L5/S1 and no HNP. The patient has had a lumbar facet injection. EMG indicates there is a possibility of L2/3 radiculopathy. There has been left knee pain for 2 years. The notes indicate that therapy has been maintenance for 8-9 months. The patient has plateaued and further progress is not anticipated.

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

The patient has a long history of back pain with a spinal fusion in 2000. There is no acute pathology on MRI. The knee range of motion is functional. The notes indicate there has been no additional progress in PT and that therapy has been maintenance. This does not meet ODG guidelines for PT. Functional improvement should be anticipated or demonstrated in PT in order for supervised therapy to continue. The reviewer finds that medical necessity does not exist for Physical Therapy, 4 visits for the lumbar spine.

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)