

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 2xWk x 4Wks 97140 97010 97012 97110 97530 97035

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

M.D., Board Certified Orthopedic Surgeon

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

Peer Review 09/21/10, 10/05/10

Emergency Department Record 04/30/09

Dr. OV 05/08/09, 05/15/09, 11/16/09, 03/15/10, 03/22/10, 05/10/10, 06/09/10, 08/18/10, 10/12/10

Orthopedic OV 12/09/09, 01/04/10,

Dr. OV 04/07/10, 08/26/10,

DR. / DDE 08/30/10

Dr. OV 09/01/10

Physical Therapy progress note 09/10/10

Procedure 03/26/10, 04/16/10

X-ray lumbar spine 04/30/09

MRI lumbar 12/29/09

EMG/ NCS 02/03/10

MD Rx 07/07/10

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Pain : Physical Therapy Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant who reportedly fell from a ladder on xx/xx/xx, which resulted in low back pain. The claimant was initially evaluated in the Emergency Department and diagnosed with low back pain and lumbar contusion. X-rays of the lumbar spine were unremarkable. The claimant continued to treat conservatively throughout 2009 with medications. A lumbar MRI performed showed some degenerative changes with a central protrusion L4-5 along with some generic mild to moderate degenerative changes. An EMG/ NCS of the bilateral lower extremities followed in February 2010, which revealed moderate left L5 lumbar radiculitis with a possible S1 component.

Physician records of March 2010 noted the claimant with intermittent left back pain with limited back motion along with hip pain. A left transforaminal epidural steroid injection was performed on 03/26/10 and 04/16/10. A left sacroiliac joint injection was also performed on 04/16/10. A 05/10/10 physician record revealed the claimant referred for an initial low back evaluation for physical therapy.

A spine evaluation dated 09/01/10 noted low back pain and left lower extremity radicular pain continue to be reported. Completion of a recently started physical therapy program was recommended with a good home exercise program for chronic maintenance of back and secondary back prevention.

A physical therapy progress note dated 09/10/10 revealed the claimant had completed ten visits of therapy which consisted of conditioning, stretching, lumbar stabilization and manual therapy. Improvement was shown in core strength with lumbar protection mechanism. Continued physical therapy was recommended to upgrade body mechanic training and lifting techniques for work.

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

This request is not medically necessary as it exceeds Official Disability Guidelines and no explanation has been provided for why there should be a divergence from the ODG in this individual's case. ODG Guidelines recommend 10 visits, and this claimant has already received 10 visits. This claimant is now one and one half years after his date of injury. The ODG would recommend he proceed with a home exercise program. Further formal therapy at this time would not be expected to improve his function beyond a home exercise program. The request exceeds guidelines and is, therefore, unsupported. The reviewer finds that medical necessity does not exist for Physical Therapy 2xWk x 4Wks 97140 97010 97012 97110 97530 97035.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Pain : Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface

Myalgia and myositis, unspecified (ICD9 729.1)

9-10 visits over 8 weeks

Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2)

8-10 visits over 4 weeks

Reflex sympathetic dystrophy (CRPS) (ICD9 337.2)

26 visits over 16 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)