

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
PT 3x5 lumbar

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board-certified in Physical Medicine and Rehabilitation
Medical Director of Rehabilitation 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

Official Disability Guidelines
Letters, 11/24/10, 12/14/10
MD 10/17/01 to 12/1/10
Family Practice 10/8/01 to 11/24/10
Healthcare 9/10/10
Hospital 10/7/02 to 11/3/10
12/23/10

PATIENT CLINICAL HISTORY SUMMARY

This claimant is a man who reported back pain on xx/xx/xx after a fall at work. His back pain is chronic. Dr. indicates he has a "disabled back" and will require medications for the rest of his life. He has 9/10 pain in the lumbar spine with tenderness on palpation. He had a cervical fusion in 2002 and has an implanted stimulator for his neck pain. He uses a Duragesic patch. He also uses Glucophage and Actos. He did have aquatic therapy in January and February of 2010. The therapist indicates that the aquatic therapy did not improve his condition. He did report some decreased pain during aquatic therapy. Additional PT is requested.

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

This is a man with a chronic painful condition who used medications for pain control as well as an implanted stimulator. His attending physician indicates he is disabled and

improvement is not anticipated. The physician indicates the patient will use medications for control of his pain for his lifetime. The ODG Pain Guidelines do recommend exercise for chronic pain. There is no sufficient evidence to support any particular exercise program over another. The ODG states the therapeutic exercise program should be initiated and the patient educated regarding independence and the importance of an on-going exercise regime. ODG states exercise is associated with a substantial and significant reduction in pain after adjusting for gender, BMI and attrition. The ODG would recommend that at this point the patient could be independent in a HEP, however continued supervised therapy would not be considered medically necessary according to the ODG. The reviewer finds there is no medical necessity for PT 3x5 lumbar.

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)