

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/17/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Nine (9) Sessions of Kinetic Activity 3x/week x 3 weeks(CPT 97110)

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

Chiropractor  
AADEP Certified  
Whole Person Certified  
TWCC ADL Doctor  
Certified Electrodiagnostic Practitioner

**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**

OD Guidelines

Adverse Determination Letters, 1/20/09, 2/2/09

1/13/09

DC, 1/7/09, 1/21/09, 1/8/09, 1/9/09, 1/10/09, 1/12/09, 1/13/09, 1/14/09, 1/15/09, 1/16/09, 1/17/09, 1/19/09, 1/21/09, 1/28/09, 1/26/09, 1/23/09

Initial Medical Report, 1/8/09

Patient Care History, 1/7/09

**PATIENT CLINICAL HISTORY SUMMARY**

The injured worker was injured on xx/xx/xx, when he injured his low back. He fell under the care of Dr., who placed him into physical therapy for 9 sessions. 9 additional sessions of therapy are being requested at this time. Records indicate that the injured employee was

going to return to work.

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

The injured employee currently does not meet the ODG for an additional 9-sessions of physical therapy. The ODG recommends 10 sessions over 8 weeks of physical therapy, of which 9 sessions have already been performed. The injured employee does not meet the requirements per ODG and documentation provided does not support additional treatment beyond and outside the ODG. The reviewer finds that medical necessity does not exist for Nine (9) Sessions of Kinetic Activity 3x/week x 3 weeks(CPT 97110).

**ODG Physical Therapy Guidelines –**

Allow for fading of treatment frequency (from up to 3 or more 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, including assessment after a "six-visit clinical trial"

Lumbar sprains and strains (ICD9 847.2)

10 visits over 8 week

Sprains and strains of unspecified parts of back (ICD9 847)

10 visits over 5 week

Sprains and strains of sacroiliac region (ICD9 846)

Medical treatment: 10 visits over 8 week

Lumbago; Backache, unspecified (ICD9 724.2; 724.5)

9 visits over 8 week

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8)

Medical treatment: 10 visits over 8 week

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 week

Post-surgical treatment (arthroplasty): 26 visits over 16 week

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 week

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**