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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3xWk x 2Wks Lumbar spine 97112, 97110, 97140

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

MD, Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics. Medical Director of 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

Official Disability Guidelines

11/5/10, 11/12/10

MRI 9/22/10

Clinic 4/8/10 to 11/8/10

Spine 6/18/10

Balance 9/13/10

4/23/10, 5/4/09

PATIENT CLINICAL HISTORY SUMMARY

This claimant has a date of birth of xx/xx/xx. He reported that he twisted his back attempting to keep a 100-pound box from falling on him. This occurred on xx/xx/xx and he has had pain since that time. He did have physical therapy treatments with. He also had chiropractic treatments in 2008 and 2009. He had an MRI on 1/5/2009 that showed a HNP at L4/5. On xx/xx/xx an MRI shows L5/S1 disc herniation with displacement of S1. He saw Dr. and surgery was being contemplated as of 6/10/2010. He was placed at MMI on 3/11/2009 with a 0% IR by a DD. Six sessions of physical therapy are being requested.

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

The medical necessity for continued physical therapy is not established by these notes. The claimant had therapy for back pain and was returned to work light duty. He was given an IR of 0%. There is no support for supervised therapy over an independent exercise program.

The reviewer finds that medical necessity does not exist for Physical Therapy 3xWk x 2Wks Lumbar spine 97112, 97110, 97140.

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)