

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/08/2010

**IRO CASE #:**

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

12 PT sessions 97110 97112 97140

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

M.D., Board Certified, Physical Medicine & 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

Adverse Determination Letters, 4/12/10, 3/16/10

M.D. 4/19/10, 4/5/10, 3/3/10

**PATIENT CLINICAL HISTORY SUMMARY**

THE RECORDS PRESENTED FOR REVIEW INCLUDE A NOTATION THAT THIS PATIENT HAS UNDERGONE 21 SESSIONS OF PHYSICAL THERAPY AND THAT THERE WAS NO CHANGE IN THE LEVEL OF PAIN COMPLAINTS OR IMPROVEMENT IN FUNCTIONALITY. THE REQUEST FOR ADDITIONAL PHYSICAL THERAPY WAS NOT CERTIFIED. AT RECONSIDERATION THERE WAS NO ADDITIONAL INFORMATION ADDED TO THE REQUEST AND THIS WAS NOT CERTIFIED. THE APRIL 19, 2010 NOTE FROM DR. INDICATES HIS FEELING THAT FURTHER PROGRESSION CAN BE MADE IN THIS CASE, IN TERMS OF PAIN, RANGE OF MOTION, STRENGTH, TOLERANCE AND PERFORMANCE OF ACTIVITIES OF DAILY LIVING.

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

There is no noted specific diagnosis. That point notwithstanding, as per the Division mandated Official Disability Guidelines, the most physical therapy for a non-operative situation is 9 sessions and that standard has been exceeded in this case. Given that there is no reported improvement, that the requesting provider cannot supply any diagnosis that would support any treatment, and the lack of improvement to date indicating that there is no reasonable expectation of improvement, there is no competent, objective and independently confirmable medical evidence presented to support this request. The reviewer finds that medical necessity does not exist for 12 PT sessions 97110 97112 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)