

# Core 400 LLC

An Independent Review Organization  
7000 N Mopac Expressway, Second Floor  
Austin, TX 78731  
Phone: (512) 772-2865  
Fax: (530) 687-8368  
Email: manager@core400.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Apr/30/2011

**IRO CASE #:**

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

Outpatient physical therapy (PT) three (3) times a week four (4) weeks to lumbar and right hip to consist of therapeutic activities, therapeutic exercises, manual therapy, gait training, aquatic therapy, massage, hot and cold packs, electric stimulation (e-stim) and ultrasound not to exceed four (4) units per session

### 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

#### PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who slipped in water on xx/xx/xx and caught herself before she fell, twisting her right leg. She has a diagnosis of right hip sprain with pre existing arthritis, lumbar sprain, and right knee sprain. The claimant is treating with Dr. for low back, hip and thigh pain. X-rays of the lumbar spine demonstrated osteopenia. X-ray of the pelvis and right hip demonstrated mild to moderate arthritis to the right hip; osteophytes were noted. The claimant was placed on NSAIDS and physical therapy was ordered. A physical therapy evaluation was done on 11/16/10. There are therapy notes for seven visits from 12/01/10 to 12/27/10. Dr. evaluated the claimant on 12/22/10 and noted that she was doing better; physical therapy had helped. The claimant had mild tenderness to the right lumbar paravertebral musculature and right sciatic notch and mild pain with range of motion of the right hip. Records indicate that another four visits of therapy were authorized.

The visit of 03/10/11 with Dr. noted a new injury on xx/xx/xx when her shoe got stuck in a metal divider. She was evaluated for left shoulder pain at that visit. There was still some lumbar paravertebral tenderness and discomfort with forward flexion. Physical therapy was ordered for the back and right hip in addition to the shoulder and knee. The therapy was denied on peer reviews of 03/31/11 and 04/07/11.

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

The claimant is x months post injury. Official Disability guidelines recommend 10 visits of physical therapy for sprain/strain injuries. The claimant has completed at least ten visits following her injury on xx/xx/xx with improvement. There would be no indication for ongoing formal physical therapy. The ODG recommends active participation in a home exercise program at this point, which would allow for continued improvement without the need for additional formal therapy. In addition, the request includes multiple passive modalities, which would not be recommended per ODG for treatment of sprain/strain injuries.

The reviewer finds no medical necessity at this time for Outpatient physical therapy (PT) three (3) times a week four (4) weeks to lumbar and right hip to consist of therapeutic activities, therapeutic exercises, manual therapy gait training, aquatic therapy, massage, hot and cold packs, electric stimulation (e-stim) and ultrasound not to exceed four (4) units per session.

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates.

Low back:

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.

Lumbar sprains and strains (ICD9 847.2)

10 visits over 8 weeks

Hip and Pelvis:

Sprains and strains of hip and thigh (ICD9 843)

9 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 KNOWLEDGBASE

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)