

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Apr/16/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** physical therapy x 12 visits

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., Board Certified Physical Medicine and Rehabilitation and Pain 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the request for physical therapy x 12 visits is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. On this date the patient was involved in a motor vehicle accident. Diagnoses are listed as left shoulder strain/sprain, cervical sprain/strain, lumbar strain, left shoulder impingement, thoracic sprain/strain and right knee sprain. MRI of the left shoulder dated 01/16/14 revealed mild rotator cuff tendonitis without evidence of tear and laterally downsloping type-II acromion process. Lumbar MRI dated 01/16/14 revealed small posterior central disc protrusion at L5-s which does not exert direct mass effect on thecal sac or exiting nerve roots; otherwise unremarkable MRI of the lumbar spine. The patient has completed approximately 24 chiropractic/physical therapy visits to date. PPE dated 02/14/14 indicates that the patient has made good progress with his shoulder treatment. Knee and neck pain are both 0/10. His primary complaint is low back pain rated as 4/10.

Initial request for physical therapy x 12 visits was non-certified on 02/20/14 noting that the claimant has already completed at least 24 visits of PT to date without evidence of progress with objective functional improvement. The claimant has already had sufficient supervised therapy to continue with a home exercise program according to the evidence based guidelines. The claimant should do just as well with a self-directed home exercise program. There are no red flags or compelling rationale that would substantiate medical necessity of additional supervised therapy over a self-directed home exercise program. The denial was upheld on appeal dated 02/26/14 noting that the issues raised by the initial denial had not been addressed. The patient subsequently underwent left shoulder injection on 02/27/14 and was recommended for 12 post-injection physical therapy visits. Note dated 03/31/14 indicates that the patient reports that he felt great in the low back for a few hours after the blocks were performed.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained multiple sprain/strain injuries secondary to a motor vehicle accident on xx/xx/xx. The patient has completed at least 24 physical therapy visits to date. The Official Disability Guidelines support up to 10 sessions of physical therapy for the patient's diagnoses, and there is no clear rationale provided to support exceeding these recommendations. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for physical therapy x 12 visits is not recommended as medically necessary.

**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)