

# Core 400 LLC

An Independent Review Organization  
3801 N Capital of TX Hwy Ste E-240 PMB 139  
Austin, TX 78746-1482  
Phone: (512) 772-2865  
Fax: (530) 687-8368  
Email: manager@core400.com

**DATE NOTICE SENT TO ALL PARTIES:** May/27/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** PT 2xWk x 4Wks lumbar spine

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., Board Certified Orthopedic Surgery

**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 PT 2xWk x 4Wks lumbar spine is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as lifting and twisting. MRI of the lumbar spine dated 04/18/14 revealed disc and facet degenerative changes with no spondylolisthesis at L4-5 and L5-S1. At L5-S1 there is shallow broad based disc herniation which contacts and deflects the descending left S1 nerve root with potential for left S1 nerve irritation. Designated doctor evaluation dated 07/11/14 indicates that diagnoses are lumbar herniated disc and sciatica. Anticipated MMI date is 11/11/14. Post designated doctor evaluation dated 09/04/14 indicates that the patient reached maximum medical improvement as of 06/05/14. At that time he had sufficient time to recover and heal from a thoracic strain. The patient was provided 0% whole person impairment. Office visit note dated 12/22/14 indicates that the patient had completed 8 sessions of physical therapy as of that date followed by L5 epidural steroid injection x 2. He is 20% improved after epidural steroid injections and physical therapy. He has 70% axial and 30% radicular pain. He has not returned to work. Assessment notes herniated lumbar disc, lumbar spondylosis and lumbar pain. Office visit note dated 04/08/15 indicates that the patient continues to report muscle tightness and weakness. The patient was recommended to continue skilled therapy to progress core and lumbar strengthening and stabilization. Current medications are dextroamphetamine, cyclobenzaprine, hydrocodone-acetaminophen and pantoprazole. On physical examination lumbar range of motion is flexion 25%, extension 15%, bilateral side bending 40% and bilateral rotation 30%. Straight leg raising is positive on the right at 55 degrees and on the left at 40 degrees. Strength is 4/5 to 4/5 in the lower extremities.

Initial request for PT 2 x wk x 4 wks lumbar spine was non-certified on 04/16/15 noting that the patient completed 18 additional physical therapy visits after 12/22/14, but records do not outline evidence of substantive and lasting improvement. The patient's symptoms were not significantly diminished and objective findings likewise did not outline substantial gains. The patient was already afforded significantly more PT sessions than the maximums suggested by the guidelines, and exceptional circumstances or other supportable reasons for 8 more/34 total PT sessions at this point were not delineated. The denial was upheld on appeal dated 05/01/15 noting that the requested 8 sessions of PT on top of the previously completed

sessions exceeds guideline recommendations for the patient's condition. The total number of sessions completed was not clearly specified. No significant improvement was documented on the recent course of PT. No exceptional factors were noted to warrant an excessive therapy regimen.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries in xx and has completed at least 20 physical therapy visits to date. The Official Disability Guidelines support up to 10 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. Post designated doctor evaluation dated 09/04/14 indicates that the patient reached maximum medical improvement as of 06/05/14. At that time he had sufficient time to recover and heal from a thoracic strain. The patient was provided 0% whole person impairment. 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 PT 2xWk x 4Wks lumbar spine is not recommended as medically necessary and the prior denials are upheld.

**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)