

Vanguard MedReview, Inc.

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Notice of Independent Review Decision

May 8, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Physical Therapy 2 X 3

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

This physician is a Board Certified Physical Medicine and Rehabilitation Physician with over 18 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who injured herself on xx/xx/xx. She was seen on xxxxxx at Medical Center with complaints of back pain and LE pain as well as a burning sensation in both LE.

12/24/2013: CT L-Spine W/O Contrast. **Impression:** 1. Multilevel degenerative changes with posterior disc bulges with probable superimposed central disc protrusion is noted at L3-4 and L4-5. There is central spinal stenosis at both L3-4 and L4-5. Follow-up MRI would be helpful for further anatomic characterization if clinically indicated.

01/24/2013: MRI L-Spine without contrast. **Impression:** Multilevel endplate bony hypertrophy, loss of disc signal/height and/or facet/ligamentum flavum

hypertrophy. 2. L3/4, L4/5 and L5/S1 focal disc protrusion/herniations. 3. L4/5 annular tear.

01/31/2014: Patient Evaluation. **Subjective:** Chief complaint of pain in the lumbar radiating to bilateral legs. She has had limited relief in the past with Tramadol and ibuprofen. The pain is located in the lumbar spine radiating to the left. **PE:** Spinous processes are non tender to palpation. Straight leg raise positive when lifting leg in supine position bilateral. Sitting straight leg raise positive on the left. Reflexes, patellar and ankle, 2+ bilaterally. **Assessment:** Lumbar Strain ICD#847.2 **Follow Up:** Start Physical Therapy, Start Neurontin, RTC in one month.

02/10/2014: Patient Examination. **Subjective:** The patient indicated on her visit today that she is feeling constant moderately severe pain in the lower back. This is further described as constant moderately severe restricted movement and tingling sensations and pins and needles and numb sensations as well as throbbing and burning pain left gluteal area, right gluteal area, left lower lumbar areas, right lower lumbar area, left thigh in the upper posterior medial aspect, left thigh in the lower posterior medial area, left popliteal region, left calf, left anterior tibial area, right thigh on the upper posterior medial aspect, right thigh in the lower posterior medial area, right popliteal region, right calf, right anterior tibial area, lateral right foot and lateral left foot. The low back pain appears to be made a lot worse by lifting and walking. Ms. feels that massaging makes her more comfortable. A 1 to 10 pain scale was used for Ms. to assess her current status. She assessed her low back pain a 7. **Medications:** 1. Ultracet 2. Robaxin one po bid **ROM:** Lumbar: Flexion: 35° severe pain, burning. Extension: 10° Severe pain, burning. Right lateral flexion: 15° Moderate pain, burning. Left lateral flexion: 15° Moderate pain, burning. **Objective:** On palpation examination a severe intensity of pain at L1-L5 bilaterally was elicited. There was indication of a medium degree of edema at L1-L5 bilaterally. The muscles showed complete spasm of the lumbar paraspinal muscles bilaterally. Kemp's test and Straight Leg Raise test positive bilaterally. **Diagnosis:** 847.2 Lumbar Sprain 729.2 Neuralgia, Neuritis, and Radiculitis, Unspecified. **Assessment:** The status of the patient's condition has changed as treatment progresses. The patient is now in a subacute phase. **Plan:** The patient will be seen three times per week for the next four weeks for: 1. Application of manual therapy to reduce muscle spasms and increase blood flow to the injured region. 2. Neuromuscular re-education. 3. Referral to medical pain management for possible injection therapy in conjunction with the therapeutic exercise program. 3. Therapeutic exercises 97110 X 3

02/12/2014: UR performed by Utilization Review Department The service(s)/treatment(s) requested are approved and outlined as follows: PT 3X4 Start Date: 02/11/14 End Date: 05/10/14

02/12/2014: Functional Capacity Evaluation. **Diagnosis:** 1.0- Lumbar disc disorder pain 2.0- Myalgia **Conclusions and Recommendations:** Based on the data obtained throughout this 4 hour evaluation, Mrs. is currently in a sedentary work classification as determined by NOISH standards. It is medical opinion of the

evaluator that she is currently unable to perform his normal work duties without the risk of re-injury to herself. Test data also indicated that Mrs. appears ready to begin an aggressive functional rehabilitation program designed to improve her muscle strengthening, ROM, physical endurance, and functional ability in relation to work activities. A program such as active physical therapy medicine will be effective in addressing Mrs. functional deficits in a time efficient manner as well as her postural issues. Follow up with a MRI, pain specialist and orthopedic healthcare provider is also indicated at this time. **Biomechanical Evaluation:** Balance: Patient displayed a rt-leg unilateral stance. Heel toe walk performed poor Lft leg unilateral stance unable. Gait: Patient presented with decreased left push-off; a wide-based gait; a stiff gait; prolonged weight-bearing on rt stance phase. Posture: Patient presented with right iliac crest higher than the left. **Manual Muscle Testing:** Lumbar Flexors 4; Extensors 4; Right Lateral Flexors 4; Left Lateral Flexors 4; Right Rotators 4; Left Rotators 4. **Key Muscle Testing:** Psoas= Fair/Fair; Quadriceps= Poor/Fair; Anterior tibialis= Fair/Fair; Flexor hallucis longus= Fair/Fair; Hamstrings= Poor/Fair; Gluteus maximus= Fair/Fair; Gastrocnemius= Fair/Fair.

02/24/2014: Physical Examination. **Subjective:** The patient indicated on her visit today that there is a significant increase in the severity of the lower back pain. Ms. was asked to determine her opinion of her current condition status. Based on a 1 to 10 pain scale, Ms. estimated her low back pain at 10. **Medications:** 1) Ultracet one po q 8 h prn p 2) Robaxin one po bid **Findings:** Examination performed by palpation over the spinal vertebral segments showed severe pain and discomfort at L1-L5 bilaterally. There is evidence elicited on palpation of moderate edema at L1-L5 bilaterally. The muscles showed marked spasticity of the lumbar paraspinal muscles bilaterally. **Diagnosis:** 847.2 Lumbar Sprain 729.2 Neuralgia, Neuritis, and Radiculitis, unspecified **Spinal ROM:** Lumbar: Flexion 30° Severe pain, burning. Extension 10° severe pain, burning. Right Lateral Flexion 10° severe pain, burning. Left Lateral Flexion 10° severe pain burning. **Plan:** The patient has reached a subacute status. The treatment schedule is for 3 visits per week for 4 weeks. Procedures: Muscle Testing, manual (sep proc) w/report; extremity/trunk was given. Treatment consisted of neuromuscular reeducation to the low back region, in order to retrain the affected musculature to increase mobility and strength. Manual therapy was administered to the area of the low back. Treatment included therapeutic exercises consisting of walking and jogging on treadmill, use of an aerodyne bike, specific therapy band exercises, and the use of targeted cybex weight equipment to the lumbar spinal area. Normal work duties are unable to be performed by the patient.

02/26/2014: Nerve Conduction Studies, Evoked Potential Studies and Needle EMG Studies. **Impression:** 1. Lumbar radiculopathy involving the left L5 and S1 nerve roots, which was indicated by increased reinnervation potential activity recorded in L5 and S1 innervated paraspinal and distal musculature within the left lower extremity (724.4) 2. 782.0 bilateral.

02/28/2014: Patient Examination. Patient continues with severe low back pain radiating down to her legs, mainly her right leg. Her pain has increased recently.

Medications reported as helping. **Recommendations:** Continue physical therapy.

03/10/2014: UR performed. Rational for Denial: Genex CGT guidelines for acute back pain suggest a maximum of 9-12 visits over 8 weeks. Re-evaluation every 2-4 weeks for documentation of progress and continued functional deficits that would require additional therapy is needed for additional skilled care. In this case, it is noted that the claimant has been previously approved for 12 sessions of physical therapy. Physical therapy provider notes were not included with the documentation submitted for review. Without review of the response to the initial 12 sessions authorized, the need for the treatment beyond the recommended guidelines is not justified. This request is not supported by the clinical documentation or the established medical guidelines. Recommend non-certification.

03/14/2014: Patient Examination. **Assessment:** The patient has now entered a more intermediate stage. She assessed her low back pain at 7. **Objective:** Kemp's Test and Straight Leg Raise Test positive bilaterally. A moderate level of pain and discomfort at L1-L5 bilaterally was elicited on examination of the spine. Moderate edema at L1-L5 bilaterally was indicated on palpation examination of the spinal tissues. The muscles showed moderate hypertonicity of the lumbar paraspinal muscles bilaterally. **Diagnosis:** 847.2 Lumbar Sprain 729.2 Neuralgia, Neuritis, and Radiculitis, unspecified **ROM:** Lumbar: Flexion 40° Moderate Pain, burning. Extension: 15° Moderate pain, burning. Right Lateral Flexion 15° moderate pain, burning. Left lateral flexion 15° moderate pain, burning. **Plan:** The patient is scheduled for treatment 3 times per week for the next 4 weeks.

03/26/2014: Office Visit. **Subjective:** Patient is complaining of increased low back pain that she currently rates her pain as constant, sharp and burning 7/10 with radiation into the right lower extremity. She was referred to our office. The patient is currently taking Methocarbamol, Tramadol, Zolpidem, Hydrocodone, and Diazepam prescribed. Her low back pain is predominantly in the center radiating out to the right buttock and down to the foot occasionally, but constantly to the mid-thigh and right knee. Treatments attempted: Physical Therapy, Chiropractic Care, Medications. **Diagnosis/Assessment:** Lumbar Displacement 722.10, Muscle Spasm 728.85, Lumbar Neuritis/Radiculitis 724.4, Backache NOS 724.5 **Plan:** 45 minutes spent with patient. Greater than 50% of the office visit was dedicated to counseling, reviewing tests & labs, treatment options and follow up plans. No prescriptions were given during this encounter. Provider has a qualified e-prescribing system. E-prescribing No Rx:: G8445 Take all medications as prescribed, Continue Physical Therapy. Procedure Requested: Transforaminal ESI-Cervical-Each Additional-Bilateral:64480-50, Transforaminal ESI-Cervical-Each Additional-Bilateral:64480-50, Epidurogram/Neurogram: 72275, Fluoro Guidance/ Localization of Needle or catheter.

03/26/2014: UR performed. Rational for Denial: Regarding additional physical therapy, a prior denial of the requested intervention on 03/10/14 is noted. Prior report notes that physical therapy provider's notes were not included with the

documentation submitted for review. Guidelines note additional therapy based on documented evidence of objective functional improvement and progression of therapy goals and documentation of ongoing functional deficits. In this case, the claimant continues to have severe low back pain. It is noted that the claimant was approved for 12 sessions of physical therapy. However, there is no indication whether the claimant has responded well with prior physical therapy to warrant the request. Moreover, there is limited evidence of sustained objective and functional gains from prior physical therapy which supports additional skilled intervention. At this point, the claimant is expected to be well-versed in an independent home exercise program to address the remaining deficits. Thus, the medical necessity for the proposed intervention is not established.

04/11/2014: Patient Examination. **Subjective:** Patient presents today and indicated that there hasn't been any significant improvement in the lumbar region pain. reported her low back pain at 7, based on a 1 to 10 pain scale.

Assessment: The spinal tissues were evaluated by palpation and showed evidence of a medium degree of pain at L1-L5 bilaterally. Examination showed moderate swelling at L1-L5 bilaterally. **Plan:** The current recommended treatment at this time is three (3) weekly visits over the next four (4) weeks. At that time the patient's condition will be re-evaluated.

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

The original adverse determinations are upheld. Submitted clinical information notes approval of 12 visits of PT, but there is no documentation of the number of visits attended, compliance with attendance or treatment, the progress with treatment regarding improvement or regression in symptoms, range of motion, strength or function or instruction in a home exercise program. For these reasons, Additional Physical Therapy 2 X 3 is not medically necessary at this time and should be denied.

Per ODG:

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. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#), including assessment after a "six-visit clinical trial".

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):

10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846):

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5):

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

Intervertebral disc disorder with myelopathy (ICD9 722.7)

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis (ICD9 724.0):

10 visits over 8 weeks

See 722.1 for post-surgical visits

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):

10-12 visits over 8 weeks

See 722.1 for post-surgical visits

Curvature of spine (ICD9 737)

12 visits over 10 weeks

See 722.1 for post-surgical visits

Fracture of vertebral column without spinal cord injury (ICD9 805):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury (ICD9 806):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Work conditioning (See also [Procedure Summary](#) entry):

10 visits over 8 weeks

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)**