

Health Decisions, Inc.

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11/26/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Physical Therapy; concurrent; Lumbar; 2x6 weeks; completed 5; 97110; dx M54.5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: American Board Certified Physician in Physical Med. and Rehab with over 20 years' 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female who has history of persistent low back pain as well as left hip/buttock pain with pain predominantly in the left hip/buttock region since a work injury on XX/XX/XX that reportedly involved working and being tripped by a X and falling landing on her left hip region onto a hard floor. Request is for additional Physical Therapy.

08/18/15: Progress note: This is a patient that is being seen in pain management for evaluation of low back pain and left leg pain. The pain developed acutely on. It is a 8/10 in severity, has been aching a dull and a sharp quality and radiates into the left buttocks and hamstring, toes distribution. The pain has been constant. The patient states the pain is aggravated by bending, lifting, standing for long periods of time, and walking, reaching, grabbing, running. The patient is alleviated by rest, heat and pain medication. She also reports numbness in the left lateral part of her shin and toes. She also reports weakness in the lower extremity. The patient has no prior history or back surgery. Patient denies any past medical history or surgeries. Assessment: Neuro- admits muscular weakness, tingling or numbness Musculoskeletal- admits neck pain, joint swelling, and limitation of motion, muscle cramps and ankle instability. Right lower extremity: muscle tone-normal, and sensation to light touch is intact. Left lower extremity: sensation to light touch is impaired over the left calf. Gait is normal. Diagnosis: Piriformis syndrome Instructions: Proceed with PT and at this point she does not want to do an injection. Prescribed diclofenac sodium 50mg BID.

08/28/15: Peer Review: Patient reportedly sustained an injury on XX/XX/XX while working. Reportedly she tripped on lunch. She fell forward in a twisting motion landing on her left side and injured her left hip and low back and left leg. She stated initially she had tingling and numbness on her left hip and her toes she had reported prior low back issues about xxxxxxx but did not radiate down her legs and did not require surgery.

A medical evaluation occurred on May 16, 2015. Patient was complaining of pain in the lumbar spine that radiated down her left buttock and was also reporting numbness and tingling. She denied loss of her bowel or bladder function or saddle anesthesia. Physical exam of the lumbar spine showed full range of motion with normal side bending and rotation. There was no obvious deformity upon inspection. There was no muscle spasm of the paraspinal muscles. Deep tendon reflexes of the lower extremities were noted to be hyperactive although this was not quantified. Muscle strength was noted to be decreased on the left leg. A supine straight leg raise on the right was negative. A supine straight leg raise on the left was positive. A view plane photograph of the left spine was negative for fracture or dislocation. She was diagnosed with a left lumbar sprain. Physical therapy and naproxen were prescribed. Work restrictions that limited xxxxxx from standing sitting pushing pulling walking lifting greater than 10 pounds for more than one hour per day were placed on March 24, 2015.

Physical therapy evaluations occurred on March 16, 2015 and March 24, 2015.

On March 25 the injured employee was seen. He noted that the injured employee was stating her overall symptoms had remained the same with no change to her pain or its location. Physical examination of the lumbar spine revealed decreased range of motion in flexion and extension. There was muscle spasm along the paraspinal muscles and tenderness. Deep tendon reflexes were hyperactive and sensation was decreased at the L5-S1 nerve root. Extreme muscle weakness was noted in the quadriceps and hamstrings. Right and left leg raises were negative the diagnosis of lumbar sprain was continued in a new diagnosis of a left displacement of a lumbar vertebral disc with myelopathy and left leg injury to multiple nerves of the pelvic girdle and lower limb were noted. The recommendations were for her to continue with physical therapy and continue taking naproxen and Flexeril. She was referred for an MRI of the lumbar spine without contrast work restrictions were extended until April 3, 2015 which limited standing and sitting to 1.5 hours per day, pushing pulling to no more than one hour per day, walking no more than two hours per day, no lifting or carrying objects greater than 5 pounds for more than one hour per day, and she was also taking breaks of 10 minutes every two hours.

An MRI of the pelvis was completed on March 26, 2015. No acute osseous articular or intramuscular abnormality involving the pelvis or bilateral hips. Lobulated left adnexal lesion measuring up to 3.3 cm demonstrates signal characteristics most consistent with an Endometrioma. Additional differential would include hemorrhagic cyst. Recommend follow-up ultrasound to assess for stability changes. Additional homogenous T2 hyperintense lesion seen in the left pelvis is likely a dominant follicular cyst measuring 3.5 cm.

An MRI of the lumbar spine was completed on the same day. Normal MRI examination of the lumbar spine and 2. No disc protrusion, disc bulging, or spinal stenosis present.

xxxx XX was seen for a follow-up at on March 30, 2015. At this visit noted that her symptoms have decreased as well as her pain. She was also stating that her range of motion has improved and the radiating pain has decreased as well. Physical examination of the lumbar spine revealed no obvious deformity and range of motion to include flexion and extension. There was no tenderness or muscle spasm. Deep tendon reflexes remained hyperactive and decreased since Seshan of the L5 – S1 nerve root persisted. Straight leg raise testing was negative bilaterally. The 3.3cm pelvic adnexal lesion was mentioned under special testing. There was no new diagnosis and medical provider recommended that Miss continue physical therapy naproxen and Flexeril.

A follow-up medical appointment occurred on April 9, 2015. The injured employee was stating that her symptoms and pain had remained the same since previous visit. She was still complaining of radiating pain from the left upper posterior thigh and buttocks to the left pubic rami. They reported numbness in the left hand also resolved, per her report. Physical examination of the lumbar spine revealed no obvious deformities, range of motion to include flexion and extension more normal and there were no muscle spasms or tenderness. She remained neurovascularly intact. Deep tendon reflexes were noted to be hyperactive. Muscle strength was noted to be decreased slightly in the quadriceps and hamstrings. A bilateral straight leg test was negative. On May 13, 2015 a follow-up evaluation occurred at where xxxxx was evaluated. The injured employee was reported that her overall symptoms had remained the same with no improvement in her pain or range of motion. Physical examination of the lumbar spine showed decreased range of motion in all planes. Inspection revealed no obvious deformities. There was no muscle spasm and tenderness

was noted to have remained the same. noted that the injured employee was pending an appointment with an orthopedic surgeon.

On June 26, 2015 the injured employee underwent an orthopedic evaluation. Physical examination of the lumbar sacral spine revealed bilateral para lumbar and left-sided tenderness to palpation range of motion was noted to be severely limited in each direction; especially on extension period muscle tone was noted to be five out of five of the left hip flexion and straight leg test and Faber tests were negative bilaterally. Deep tendon reflex were noted to be 2+ bilateral. Her posture and gait were noted to be guarded. The medical provider's assessment was pisiformis syndrome on the left and he opined that had pisiformis syndrome rather than radiculopathy and that she required services of a different therapist that was familiar with this problem he also recommended that she consider injection for pain.

09/11/15: Order Requisition Report: Physical Therapy 2-3x/wk x 4-8 weeks

09/17/15: History and Physical: Patient walked independent with an antalgic gait pattern. Patient had notable right knee valgus, with limited knee and hip flexion and trunk rotation bilaterally. Patient was agreeable and tolerated evaluation and treatment well. Patient symptoms were easily aggravated with left hip movement. Patient began crying at one point due to frustration; she stated she is tired of feeling like an 80 year old man. Patient had noted atrophy along left lateral thigh compared to right lateral thigh. Patient has significant lack of strength on her LLE as compared to her RLE. Patient anterior and posterior hip-sacral area was aggravated by FADIR and FABER movements; patient reported impingement like pain at hip and across inguinal ligament. When performing functional step down test, patient demonstrated severe deviations in the LLE, with significant IR and adduction at left hip. When completed on RLE, patient only had minimal IR and adduction deviations. Patient was issued an Home exercise program that focused on stretching quads and piriformis, strengthening for hip extensors and abductors, as well as heel slides in supine to establish eccentric control of left hip flexors. Thank you for referral of this patient.

09/21/15: Physical Therapy Pre-authorization Request: Requesting physical therapy: lumbar 12 visits; 97110, 97140, 97112, 97116, 97535, G0283 dx 724.2

10/19/15: Progress note Physical therapy: Patient progressing well as of late as her program has changed. Per patient she feels as if her pain is moving around slightly at times but is still in posterior hip area. Patient has shown recent improvement activity tolerance and confidence with performance. Patient still states higher pain levels much improved from IE and that she is having more tolerance to activity. Patient states that she is still mentally keeping herself from doing things since she is worried about her pain levels increasing but that this is improving as well. Per patient she would like to continue and she would continue to benefit from further formal physical therapy. Per patient she has to accompany her ill at the beginning and will be unable to attend at that time but will be diligent with HEP performance. HEP was updated today for further home performance as well as some home soft tissue self-mobilizations was given as well. Patient to be extended for 6 weeks rather than 4 to make up for time out of the country. Continue per POC for progression of mobility and stability training. Frequency 2xweek- duration 6 weeks.

10/23/15: UR: I recommend a denial of the requested therapy. First the patient is eight months status post injury and has completed 18 sessions of therapy. The requested physical therapy greatly exceeds the recommendations of the ODG (10 visits over 8 weeks). Second, the documentation fails to outline special circumstances in this case that would justify therapy greatly exceeding guideline recommendations. Third, after 18 sessions of therapy and 2 different therapy strategies the patient should be capable of continuing with a self-directed home exercise program. Fourth, the records did not include a recent problem focused evaluation outlining the medically necessity of skilled therapy versus continuation with a home program.

10/30/15: UR: The request was previously denies on October 23, 2015 due to lack of substantial deficit on examination and the request exceeding the ODG guidelines recommendations. Additional documentation was submitted with the progression note from October 19, 2015 suggesting that the patient has had 5 sessions of therapy which contradicts the prior documentation the patient has had at least 18 sessions of physical therapy approved to date. The request remains denied as there is contraindication regarding the extent of physical therapy. The ODG would support 10 sessions of physical therapy over eight weeks. Without clear documentation supporting

the extent of therapy to date, the request for further formal physical therapy cannot be supported. Additionally, the patient has had small improvement with more recent five therapy sessions documented as of 10/19/15. The record indicated that patient had prior approval for PT with six sessions in September 2015 and 12 sessions approved in April 2015, which exceeds the guidelines recommendations, without substantial improvement to support the medical necessity to continue to exceed the guidelines recommendations.

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

Determination: denial for an additional 12 PT visits - 2 times a week for 6 weeks for diagnosis M54.5 - low back pain is UPHeld/AGREED UPON since the request exceeds ODG recommended number visits for THIS diagnosis as well as the more recent Orthopedic diagnosis of Piriformis Syndrome - both 9 PT visits over 8 weeks, and clinically, after an UNCLEAR number of PT visits in March, 2015 for the low back and at least 5 PT visits in October of 2015 since the diagnosis of Piriformis Syndrome, there is lack of documentation of objective progress in range of motion and strength, and documentation of instruction in a home exercise program.

There is also lack of documentation regarding Orthopedic follow up visit since the more recent PT visits, and therefore lack of physician endorsement of PT plan of care. Therefore, this request for additional 12 PT visits is not medically necessary.

Per ODG:

Recommended as indicated below. A physical therapy program that starts immediately following hip injury or surgery allows for greater improvement in muscle strength, walking speed and functional score. ([Jan, 2004](#)) ([Jain, 2002](#)) ([Penrod, 2004](#)) ([Tsaou, 2005](#)) ([Brigham, 2003](#)) ([White, 2005](#)) ([National, 2003](#)) A weight-bearing exercise program can improve balance and functional ability to a greater extent than a non-weight-bearing program. ([Expert, 2004](#)) ([Binder, 2004](#)) ([Bolglia, 2005](#)) ([Handoll, 2004](#)) ([Kuisma, 2002](#)) ([Lauridsen, 2002](#)) ([Mangione, 2005](#)) ([Sherrington, 2004](#)) Patients with hip fracture should be offered a coordinated multidisciplinary rehabilitation program with the specific aim of regaining sufficient function to return to their pre-fracture living arrangements. ([Cameron, 2005](#)) A physical therapy consultation focusing on appropriate exercises may benefit patients with OA, although this recommendation is largely based on expert opinion. The physical therapy visit may also include advice regarding assistive devices for ambulation. ([Zhang, 2008](#)) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. ([Larsen, 2008](#)) Behavioral graded activity (BGA) is an individually tailored exercise program in which the most difficult physical activities are gradually increased over time and the exercises are specifically designed to improve impairments limiting the performance of these activities. In the long-term, both BGA and usual PT care were associated with beneficial effects in patients with hip and knee OA. In patients with knee OA, there were no between-group differences at short-, mid-long, and long-term follow-up. In contrast, patients with hip OA had significant differences favoring BGA. ([Pisters, 2010](#)) For patients with hip replacement, earlier and more intensive rehabilitation was associated with better outcomes. ([Dejong, 2009](#)) The most successful hip fracture PT programs involve more intensive exercise, but PT is often prescribed in doses and modalities that are insufficient to generate physiological adaptation. The potential risks of more intensive physical therapy appear to be minimal. ([Stott, 2011](#)) A Cochrane review on in restoring mobility after hip fracture surgery provides limited guidance, with inconsistent results from various trials. Some trials found improved mobility from a two-week weight-bearing program, a quadriceps muscle strengthening program and electrical stimulation aimed at alleviating pain. There was no significant improvement in mobility from a treadmill gait retraining program, 12 weeks of resistance training, and 16 weeks of weight-bearing exercise. Of two trials evaluating more intensive physical therapy regimens, one found no difference in recovery, and the other reported a higher level of dropout in the more intensive group. Started soon after hospital discharge, two trials found improved outcome after 12 weeks of intensive physical training and a home-based physical therapy program. Begun after completion of standard physical therapy, one trial found improved outcome after six months of intensive physical training, one trial found increased activity levels from a one year exercise program, and one trial found no significant effects of home-based resistance or aerobic training. Another trial found improved outcome after home-based exercises started around 22 weeks from injury, and a trial found home-based weight-bearing exercises starting at seven months produced no significant improvement in mobility. ([Handoll, 2011](#)) See also more specific topics listed separately: [Active release technique](#) (ART) manual therapy; [Aquatic therapy](#); [Bed rest](#); [Brace](#); [Chi machine](#); [Chiropractic treatment](#); [Closed reduction](#); [Complimentary and alternative medicine](#) (CAM); [Computer-aided training](#); [Continuous passive motion](#) (CPM); [Cryotherapy](#); [Diathermy](#); [Education](#); [Exercise](#); [Gait training](#);

[Gym memberships](#); [Hip protectors](#); [Hip-spine syndrome](#); [Home health services](#); [Hydrotherapy](#); [Low level laser therapy \(LLLT\)](#); [Magnet therapy](#); [Manipulation](#); [Reflexology](#); [Return to work](#); [Sacroiliac problems, diagnosis](#); [Sacroiliac support belt](#); [Skilled nursing facility \(SNF\) care](#); [TENS](#) (transcutaneous electrical nerve stimulation); [Traction](#) (manual); [Vasopneumatic devices](#); [Walking aids](#) (canes, crutches, braces, orthoses, & walkers); [Work](#); [Work conditioning, work hardening](#).

ODG Physical Medicine Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less). Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#).

Sprains and strains of hip and thigh:

9 visits over 8 weeks

Dislocation of hip:

9 visits over 8 weeks

Fracture of neck of femur:

Medical treatment: 18 visits over 8 weeks

Post-surgical treatment: 24 visits over 10 weeks

Fracture of pelvis:

Medical treatment: 18 visits over 8 weeks

Post-surgical treatment: 24 visits over 10 weeks

Osteoarthritis and allied disorders:

Medical treatment: 9 visits over 8 weeks

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

Post-surgical treatment: 18 visits over 12 weeks

Arthropathy, unspecified:

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

Post-surgical treatment, arthroplasty/fusion, hip: 24 visits over 10 weeks

Piriformis syndrome:

Medical treatment: 9 visits over 8 weeks

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

9 visits over 8 weeks

In addition, active self-directed home PT may include Simple Hip-Strengthening Exercises:

Hip-flexors — Standing beside a chair, without bending at the waist, bend one knee up as close to chest as possible. Lower leg to floor. Repeat with other leg.

Hip abductors — Standing erect and holding onto the back of a chair, without bending at the waist or knee, move one leg straight out to the side, making sure that the toes point forward. Lower the leg and repeat on other side.

Hip-extensors — Stand holding onto the back of a chair, and bend forward about 45 degrees at the hips. Lift one leg straight out behind you as high as possible without bending the knee or moving the upper body. Lower leg and repeat on other side.

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)**