

# MEDRx

3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069  
Ph 972-825-7231 Fax 972-274-9022

**DATE OF REVIEW:** 6/10/15

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of Physical Therapy with a different facility.

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

The reviewer is a Medical Doctor who is board certified in 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)

The reviewer agrees with the previous adverse determination regarding Physical Therapy with a different facility.

A copy of the ODG was not provided by the Carrier/URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

is a male reportedly with low back pain since a work related injury on or about xx/xx/xx. He has had extensive physical therapy treatments consisting of 18 sessions without significant lasting benefit.

The initial evaluation on 4/20/2015 indicates that has low back pain, worsened with bending, twisting and leaning back. There is no reported leg pain, numbness or tingling. The

evaluation reveals weakness of the hip extensors, flexors, and external rotators along with knee flexors bilaterally. There is also restricted lumbar motion. The recommendation was for active therapy for 6 visits over 3 weeks' time, based on a prescription from dated 3/24/2015.

The office note from on 4/21/2105 is the only physician note available in the records. It reveals had been improving until "yesterday" when he felt a pop in his back. There were no new radicular symptoms. The claimant feels the previous therapy sessions were not helpful and included mostly arm and leg exercises. The physical exam revealed normal motor, sensory and reflex findings, negative straight leg raise test, and a normal gait. Lumbar flexion is 50 degrees and flexion is 10 degrees. Additional therapy was suggested.

Therapy notes from are handwritten and difficult to interpret but appear to show the claimant received core strengthening, gait training and aerobic conditioning exercise therapy.

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

ODG, in its "Low Back" chapter, allows for physical therapy for low back conditions. This should emphasize active therapy and avoid excessive use of passive modalities. It should allow for fading of treatment frequency with specific durations listed in the analysis section below. In this case, it appears the claimant has had adequate and active therapy of duration that actually exceeds ODG guidelines. As a consequence additional therapy sessions do not meet guideline.

**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)**

ODG, Low Back-Lumbar and Thoracic (Acute & Chronic), Physical Therapy

**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