

# CASEREVIEW

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[Date notice sent to all parties]: June 19, 2015

**IRO CASE #:**

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

12 sessions of additional lumbar physical therapy at 3 times a week for 4 weeks

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 17 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.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was injured on xx/xx/xx while driving. He was driving approximately 20 miles an hour when it went into a ditch and he was ejected from his seat hitting his back at the time of landing. He denied hitting his head, but complained of localized back pain and the inability to ambulate. Upon arriving at the ER he had a Glasgow Coma Score of 15, he was neurologically intact and a C-collar was in place. A CT scan showed a severe unstable burst fracture of L3 with severe posterior retropulsion causing compression of the cauda equine nerve roots. A MRI showed the same as the CT plus extensive epidural hemorrhage and lumbar spinal canal compressing the cauda equine nerve roots, anterior longitudinal ligament, posterior longitudinal ligament and ligamentum flavum ruptured at L3; contusion suspected in the conus medullary. He underwent a posterior instrumentation and fusion of T10-S1 with L3 laminectomy on June 3, 2014. Once stabilized he was admitted to on June 12, 2014 for intensive inpatient therapies. He was discharged on June 27, 2014.

On October 21, 2014, the claimant presented. Current medications: TraMadol HCL CR 200 mg and Norco 325-5 mg. It was reported that he was ambulatory and released by to drive. He was receiving aquatic therapy one time a week and land therapy one time a week. He was continent of bowel and bladder. He was complaining of pain and requesting Hydrocodone. Impression: Difficulty walking, gait abnormality and lumbago. Plan: Start him on Conzip 200mg and Norco 5 mg, and start physical therapy 3 times a week for gait training.

On January 21, 2015, the claimant presented using his rolling walker unaccompanied. He reported his pain was well managed with the Conzip 200mg, but he could feel some muscle spasticity when he is going to sleep at night. He reported difficulty in dressing with putting on his shoes and pants. He utilized his reacher and shoe horn for assistance. He noted weakness in his quads and slides back in his knee during his gait. He used an elevated toilet seat and bath chair for assistance in toileting and bathing. He reported receiving benefit from PT/OT and would appreciate more if possible. stated he would benefit from a muscle spasticity medication and boot hooks and boot jack. Plan: Continue Conzip and Xanaflex 2 mg. Start PT 3 times a week.

On April 22, 2015, the claimant presented ambulatory using his cane. He reported pain was well managed but that WC would not refill his prescription. He started his paperwork for Social Security Disability. He reported not getting sleep at night and felt that his mattress was the problem. discussed a prescription for a sleep number or orthopedic mattress. He also reported no strength in his hands and that he was having problems with urinating; at times going a lot and then other times just dribblingly with some noted incontinence. He would be referred to an urologist.

On April 27, 2015, UR. Rationale for Denial: At the present time, for the described medical situation, Official Disability Guidelines would not support this specific request to be one of medical necessity. This reference would support an expectation for an ability to perform a proper non supervised rehabilitation regimen for the described medical situation when an individual is this far removed from the date of injury and when an individual has received access to the amount of supervised rehabilitation services previously provided. As such, presently, medical necessity for this specific request is not established.

On May 11, 2015, the claimant presented for a physical therapy evaluation and FCE. It was noted that he was unable to counterbalance during the lifts and carry due to decreased trunk range of motion. Performance was consistent among FCE items and functional limitations noted were consistent with physical impairment and diagnosis. He consistently used a single tip cane while ambulating throughout the testing; however, he was able to complete the front carry without the cane. Based on the results, the therapist noted there was not a job match. She stated given the amount of his pain and limitation he would have extreme difficulty participating in a work conditioning program, but that he would benefit from physical therapy that addresses his remaining deficits and helps him regain function.

On May 26, 2015, UR. Rationale for Denial: The claimant has had 48 post-op physical therapy sessions. At this time, the patient should be able to do active home exercises per the Official Disability Guidelines. The Official Disability Guidelines recommends up to 34 physical therapy sessions.

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

The denial of additional 12 PT visits is UPHELD/AGREED UPON since request exceeds ODG recommended number of visits and time frame for diagnosis (fracture of vertebral column with spinal cord injury 48 visits over 18 weeks), and clinically after 48 post-operative visits there is a shift in goals beyond that which can be provided by basic physical therapy, namely simply range of motion and strength, which can be maintained by compliance with a home exercise program. There has been consideration of progressing to more formal functional rehabilitation, namely single disciplinary work conditioning, but deemed inappropriate due to pain and "limitations." There is question, therefore, regarding consideration of progression to multidisciplinary pain management/functional restoration including occupational therapy, psychological counseling and vocational counseling for a more individualized program for a such a complicated and challenging case. Therefore, the request for 12 sessions of additional lumbar physical therapy at 3 times a week for 4 weeks is not medically necessary.

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)