



Specialty Independent Review Organization

**Date notice sent to all parties:** 5/18/2016

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of additional physical therapy 3 x 3wks lower back.

**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 the prospective medical necessity of additional physical therapy 3 x 3wks lower back.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male with low back pain that radiates to his left thigh. The diagnosis offered is discogenic low back pain. Imaging studies have indicated degenerative changes. He works as a XX and the therapy notes indicated he is required to lift up to 40 pounds. He has had physical therapy treatments including pain-relief modalities, manual therapy and therapeutic exercise and has had improvement in pain scores and mobility. The most recent therapy re-evaluation indicates the patient has "minimal low back pain that interferes with ADL's, work and recreational activities." There are no indications within the records that indicate any exceptional circumstances that would cause the patient to require additional physical therapy treatments beyond his current home exercise program.

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

ODG in its "Low Back-Lumbar and Thoracic (Acute and Chronic)" chapter allows for physical therapy treatments with a fading of treatment frequency of 10 visits

over 8 weeks for most low back conditions, including the diagnosis lumbar intervertebral disc disorders without myelopathy. This is the diagnosis suggested as “discogenic low back pain” in his order dated X/X/XX. To date 10 sessions for the low back have already been completed. The therapy notes indicate that the patient is compliant with his home exercise program. The notes reviewed mention no “exceptional factors” as required under ODG to allow treatment frequency or duration that exceeds the recommended 10 visit limit. As a consequence, without any compelling factors present such as co-morbidities, or exacerbations, the request for additional therapy sessions does not meet ODG guidelines and is therefore not medically necessary.

ODG, “Low Back-Lumbar and Thoracic (Acute & Chronic)” Chapter; 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:

10 visits over 8 weeks

Sprains and strains of unspecified parts of back:

10 visits over 5 weeks

Sprains and strains of sacroiliac region:

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified:

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy:

Medical treatment: 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)**