

# CASEREVIEW

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**IRO CASE #:**

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

97110 Physical Therapy Lumbar Spine 3xwkx4wks  
97140 Manual Therapy Lumbar Spine 3xwkx4wks  
97530 Therapeutic Activities Lumbar Spine 3xwkx4wks  
97112 Neuromuscular Reeducation Lumbar Spine 3xwkx4wks  
97001 Physical Therapy Evaluation Lumbar Spine x1

**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 20 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 involved in a motor vehicle accident with an 18 Wheeler on XX/XX/XX. He sustained injuries to his neck, back, right hip and right knee. He was initially evaluated at XX in Tyler. Due to ongoing pain, he was then seen in the XX ED. There, X-rays of the Lumbar Spine showed a 20% anterior L2 compression fracture.

On XX/XX/XX, the claimant presented with moderate-severe pain located in the lower back, neck and right hip & knee. The pain radiated to the right buttock and it was described as an ache, discomforting and sharp. On examination there was tenderness at L2. He was prescribed Hydrocodone and Aspirin-81 and was taken off work to let the fracture heal. A Jewett Back brace was ordered.

On XX/XX/XX, the claimant presented and received a Thoracic Lumbar Sacral Orthosis.

On XX/XX/XX, the claimant presented in follow-up. He reported headaches, lumbar pain (was wearing his brace), knee pain (was referred to XX) and left elbow pain. It was reported that he had consulted XX at XX and XX had requested an MRI of the lumbar spine.

On XX/XX/XX, the claimant presented with low back pain rated 5-6/10. He reported the pain was improving. He

denied numbness and tingling. Treatments included anti-inflammatory medications. On physical exam, sensation was intact; reflexes were 2+ and symmetric. Gait was within normal limits. A Lumbar MRI was recommended.

On XX/XX/XX, MRI of the Lumbar Spine, Impression: 1. No significant interval change since XX/XX/XX. 2. Anterior wedging of L1 with approximately 25% anterior height loss. 3. Exaggerated lordosis of the lumbosacral junction with associated 3-4 mm retrolisthesis of L5 on S1. 4. Disc dehydration and disc space narrowing at L2-3, L4-5 and L5-S1. 5. Multilevel annular disc bulge and disc protrusion (herniation) associated posterior annular tear at L4-5 and L5-S1 and multilevel spinal stenosis, with associated impingement of the traversing nerve roots, as described above. 6. Multilevel lateral recess/subarticular neural foraminal narrowing, also with suggestion of multilevel exiting nerve root impingement, as described above.

On XX/XX/XX, the claimant presented with back pain rated 8-9/10 that radiated into the right leg. It was noted he returned to work and re-injured his back. Treatment: His MRI has not changed. He would benefit from physical therapy and injections.

On XX/XX/XX, the claimant presented for a Physical Therapy Evaluation. It was observed that the claimant had a brace on the right knee and a brace on the left elbow. He seemed to sit and stand/walk somewhat guarded. He had some tightness along the lumbar spine. He was only able to move to 30 or 40 degrees on the right with SLR before he had pain and discomfort. On the left he was able to move much more. With palpation, he had pain along the lumbar paraspinals. Problem List: Pain limits functional activities, decreased ROM preventing full functional activity, decreased strength limiting functional activities, and decreased participation in recreational activities. Recommendation: PT 3 times a week for 4 weeks.

On XX/XX/XX, XX, UR. Rationale for Denial: I spoke to XX, PA on XX/XX/XX at 2:04PM. She stated that the claimant had attended some physical therapy for the lumbar spine more proximal to the incident date. She stated that they had been following the claimant and that he had been doing well until he returned to work around XX/XX and "re-injured" his low back. They saw the claimant in early XX and ordered imaging. They last saw the claimant on XX/XX/XX. She did not know if the claimant continued to work. She did not have any up to date information. The claimant's current condition is unknown. The claimant should at least be re-evaluated to determine the need for additional treatment. XX agreed to have the claimant come in for a follow up visit. Adverse determination is rendered at this time.

On XX/XX/XX, UR. Rationale for Denial: The patient is documented as having completed supervised rehab previously. Whether or not this included PT for the low back is not documented. Response to prior supervised rehab is not documented. The last office note is from XX. There is note of a "re-injury" in XX/XXXX. Details are not documented. There is no documented evidence of a currently ongoing occupational musculoskeletal condition amenable to treatment with supervised rehab at this juncture. This request is not supported with the documentation submitted for review.

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

Denial of 12 PT visits, 3 times a week for 4 weeks for procedural codes 97110, 97140, 97530, 97112 and 97001 is UPHeld/AGREED UPON since the request exceeds timeframe for treatment with basic physical therapy visits, and clinically after completion of unknown number of PT visits after the injury, there is no documentation of compliance with attendance, progress with treatment, or instruction in/compliance with a home exercise program, to warrant medical necessity for additional basic PT visits now 9 months since injury.

#### **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:**

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

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**

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

**Spinal stenosis:**

10 visits over 8 weeks

**Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified:**

10-12 visits over 8 weeks

**Curvature of spine:**

12 visits over 10 weeks

**Fracture of vertebral column without spinal cord injury:**

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

**Fracture of vertebral column with spinal cord injury:**

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

**Torticollis:**

12 visits over 10 weeks

**Other unspecified back disorders:**

12 visits over 10 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)