Medical Assessments, Inc.

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IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
PT left chest/rib 3x4

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Physician in Family Medicine with over 18 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 XX that was injured on XXXX. While XX was XX. XX diagnosis include pain in thoracic spine, fracture of one rib, left side, initial encounter for closed fracture.

XXXX: UR performed by XX. Rationale for denial: Based on review of the medical records provided the proposed treatment consisting of Physical Therapy left chest/rib 3x4 is not appropriate and medically necessary for this diagnosis and clinical findings.

XXXX: Progress notes by Office visit by XX. Claimant was seen for follow up visit. XX symptoms are stable since last visit. XX discomfort is most prominent in the left, mid thoracic spine. The pain does not radiate. XX characterizes it as constant and severe. Claimant received PT on XXXX and XXXX. Findings include unable to work and has pain rated as a 5-7/10 on a visual analog scale. XX reports that XX has pain but feels better than when XX first came in. There is no detailed discussion of sustained functional improvement from prior course of pt. There is no discussion of daily home exercise program. There are no therapy goals and no change in therapy program detailed. Current exam shows decreased ROM /strength on mid back. Tenderness to palpation on mid left anterior/lateral rib cage. Thoracic region showed moderate restriction on left thoracolumbar paravertebral muscle. On XXXX ROM was extension 5%, flexion was 10%, rotation left was 5%, rotation right was 5%, side bending left was 5%, side bending right was 10%. On XXXX, ROM was extension 10%, flexion was 30%, rotation left was 5%, rotation right was 10% side bending left was 5% and side bending right was 10%. Manual muscle testing done. This claimant has had XX sessions with no documented re-injury.

XXXX: UR performed by XX. Rationale for denial: Based on review of the medical records provided the proposed treatment consisting of Physical Therapy left chest/rib (12 visits) is not appropriate and medically necessary for this diagnosis and clinical findings.

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

The decision to uphold the denial of further Physical Therapy for left rib fracture is based on ODG Guidelines and review of available medical records. The patient has had at least a XX trial visit with no documented re-injury and minimal improvement, i.e. Improvement in extension from 5% to 10% over XX, flexion 10% to 30%, and rotation 5% to 10%. Based on ODG Guidelines, XX visits is not appropriate for rib fracture and patient can be instructed in a Home Exercise Plan.

ODG Guidelines:

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
Abnormality of gait:
8-48 visits over 8-16 weeks (based on specific condition)
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)**