US Decisions Inc.

An Independent Review Organization
8760 A Research Blvd #512
Austin, TX 78758
Phone: (512) 782-4560
Fax: (512) 870-8452
Email: manager@us-decisions.com

Review Outcome

Description of the service or services in dispute:

XX of Additional Physical Therapy for the Lumbar Spine.

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Family Practice

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX who was diagnosed with other intervertebral disc displacement, lumbar region (M51.26). XX other diagnoses were bilateral low back pain with bilateral sciatica and herniated lumbar intervertebral disc.

XX sustained a work-related injury on XXXX, when XX, causing XX onto XX. XX had some pain in the mid to low back and thought it would go away, but the pain got progressively worse within XX.

On XXXX, XX presented to XX and reported that XX experienced pain and numbness in XX right leg, which got worse after prolonged periods of sitting or bending forward. XX informed that the pain started as a feeling of numbness that radiated from the back to the right upper thigh. If XX did not do stretching, the pain became more severe and XX developed weakness in the right leg. XX had completed XX work XX; however, XX felt that it may have contributed to the worsening of XX symptoms. XX was evaluated by an orthopedist, who had disagreed with XX at the point and felt that the next step should be physical therapy. Unfortunately, physical therapy had been denied. On examination, tenderness to palpation was elicited over the lumbar spine on the right side along with positive straight leg raising test. There was also decreased muscle strength on the right side. On XXXX, XX continued to experience symptoms that were consistent with right-sided sciatica as well as pain on the left side. XX stated that after sitting for even a short period of time when XX stands, XX developed pain and numbness shooting down the back of XX right leg with radiation to the right foot. At times, it would even cause foot-drop. XX also experienced similar symptoms on the left side, only slightly less in severity. On examination, tenderness to palpation was elicited over the lumbar spine with tenderness down the right sciatic region and positive straight leg raise test at 30 degrees.

The treatment to date included medications, extensive physical therapy and work conditioning program (completed).

An MRI of the lumbar spine dated XXXX revealed foraminal protrusion most evident on the left at L2-L3 with associated foraminal narrowing as well as mild foraminal protrusion on the right at L4-L5 with right greater than left foraminal narrowing at that level. There was no canal stenosis or focal herniation. An MRI of the thoracic spine performed on XXXX demonstrated minimal degenerative change with minimal disc bulge at T9-T10 and T11-T12, otherwise unremarkable examination.

Per a utilization review decision letter dated XXXX, XX denied the request for physical therapy of the lumbar spine, XX. The rationale for denial was, “Based on submitted medical record, the claimant has been instructed on home exercises on numerous occasions and at this time, the request is for additional physical therapy. The claimant has exceeded the ODG guidelines in regards to physical

therapy for XX mid and low back. Therefore, the request for physical therapy XX of the lumbar spine, for submitted diagnosis of chronic right-sided pain, as outpatient, is not medically necessary."

A reconsideration review was performed by XX on XXXX. Per the review letter, the requested service was denied based on the following rationale: "When considering the date of injury, the injury sustained, the amount of physical therapy as well as the amount of work hardening already completed taking into account the restrictions, there is no clinical indication presented for additional physical therapy at this time. The amount of therapy requested exceeds the parameters noted for a chronic pain or an acute lumbar injury. The work restrictions note is that the individual returned to work with specific parameters identified. Therefore, there is no specific objective clinical data presented to suggest additional physical therapy is warranted."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the clinical information provided, the request XX of Additional Physical Therapy for the Lumbar Spine is not recommended as medically necessary. Per a utilization review decision letter dated XXXX, XX denied the request for physical therapy of the lumbar spine, XX. The rationale for denial was, "Based on submitted medical record, the claimant has been instructed on home exercises on numerous occasions and at this time, the request is for additional physical therapy. The claimant has exceeded the ODG guidelines in regard to physical therapy for XX mid and low back. Therefore, the request for physical therapy XX of the lumbar spine, for submitted diagnosis of chronic right-sided pain, as outpatient, is not medically necessary." A reconsideration review was performed by XX on XXXX. Per the review letter, the requested service was denied based on the following rationale: "When considering the date of injury, the injury sustained, the amount of physical therapy as well as the amount of work hardening already completed taking into account the restrictions, there is no clinical indication presented for additional physical therapy at this time. The amount of therapy requested exceeds the parameters noted for a chronic pain or an acute lumbar injury. The work restrictions note is that the individual returned to work with specific parameters identified. Therefore, there is no specific objective clinical data presented to suggest additional physical therapy is warranted." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient has undergone extensive physical therapy to date as well as a work conditioning program. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers
- ☐ Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back
- ☐ Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)