Icon Medical Solutions, Inc.

P.O. BOX 169
Troup, TX 75789
P 903.749.4272
F 888.663.6614

DATE: 8/21/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy Thoracic Spine 2x4

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: The reviewer specializes in Physical Medicine & Rehabilitation with over 25 years of experience.

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Partially Overturned (Agree in part/Disagree in part)

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]: Claimant is a XXXX who sustained original injury on XXXX or a thoracic back sprain and pain in thoracic spine. Claimant re-injured the same area on XXXX, when XXXX was XXXX and strained XXXX thoracic and scapular area.

XXXX: Office Visit with XXXX. Injured back while lifting pt on XXXX. Neg x-ray. Taking XXXX and NSAIDs. No numbness/tingling. Positive for back pain. Normal ROM. XXXX exhibits tenderness. No edema or deformity. Tender over bilateral thoracic.

XXXX: Office Visit with XXXX. States pain is not getting any better and is actually worse today. States XXXX was getting out of bed this morning and felt a sudden intense pain/pop in shoulder. No meds for pain. Positive for back pain and myalgias. Normal ROM. Refer for PT and MRI. Order XXXX of pain, severity of pain today does not make sense with injury that happened last month. I told XXXX due to XXXX extreme level of pain today, I recommend checking and MRI to make sure there isn't a more severe disc/nerve/muscular injury and also to help figure out if XXXX is faking this to get out of work.

XXXX: Office Visit with XXXX. Has been doing PT, starting to feel better. No weakness. MRI showed several herniated disc. Taking XXXX at night. XXXX. Positive for back pain and myalgias. Normal ROM. Tenderness over thoracic less sensitive than prior exam. Overall, appears to be improving. Recommend going back to work light duty, continue PT.

XXXX: Office Visit with XXXX. Recently finished PT. No complaints. Pt is experiencing no tenderness. Full ROM.

XXXX: Office Visit with XXXX. Pt re-injured back on XXXX. XXXX. Pain and spasm in right thoracic region/rhomboids. Having pain with movement/lifting or right shoulder. No swelling or ecchymosis. Positive for myalgias. XXXX exhibits tenderness on physical exam. Straight leg raise Negative. No pain on left side. Internal rotation: 0 degrees, sacrum abnormal. Normal right shoulder strength. Hawkin's test: negative. Impingement: negative. Sulcus: absent. Order XXXX. Instructed over home PT exercises and recommend going to Sports PT, may return to work with light duty restrictions.

XXXX: Physical Therapy Progress Report. Pt was back at work full duty and had to XXXX. Pt XXXX and strained R side of neck near UT and medial scapulae near rhomboid, resulting in re-injury of same area as last series of treatment. Pain at rest 2/10; with activity 9/10; sharp. Exacerbating factors; lifting one or more pounds. Relieving factors; rest. Goals for pain; decrease by 75%, not met. Scapularis tenderness, rhomboid tenderness, poor scapular control and stability, and poor AROM of R. GHJ secondary to pain. Formal PT to improve upon said impairments to complete activities of daily living, normalize home function, and to return to work as a PCA. Current Status: CK- At least 40% but less than 60% impaired, limited or restricted. Goal Status: CI- At least 1% but less than 20% impaired, limited or restricted.

XXXX: UR by XXXX. Rationale- The claimant is well past the subacute healing phase, XXXX months ago. The claimant has already had an adequate course of 8 sessions of similar therapy with documented sustained functional improvement and request is now for extensive 8 for recent flare up. There is lack of extenuating circumstances to exceed guideline. The claimant is suitable for a home exercise program alone for range of motion and strengthening exercises. Therefore, the request is not medically necessary.

XXXX: Appeal Letter. Yes, I received Physical Therapy for my initial injury date of XXXX, Thoracic Back and Thoracic Spine (1 evaluation and 6 visits). However, for my second injury on XXXX of my Thoracic Back and Thoracic Spine, I received a re-evaluation and 1 treatment. This was not beneficial to my recovery. My re-injury has not been treated in the manner of my initial injury.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse decision is PARTIALLY OVERTURNED (agreed in part/disagreed in part). After completion of 8 PT visits since the injury XXXX, there was documented improvement in pain, decrease in tenderness, and full range of motion of the thoracic spine up until an exacerbation. Therefore, the request for Physical Therapy Thoracic Spine, given ODG recommendation up to 10 PT visits for thoracic/lumbar spine sprain, an additional **2** (**TWO**) **PT visits** is considered medically necessary and appropriate so as to update a home exercise program.

PER ODG XX

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)**