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Date notice sent to all parties: 08/07/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy three times a week for six weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal Surgery

REVIEW OUTCOME:

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ 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.

Physical therapy three times a week for six weeks – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX examined the patient on XXXX after XXXX had been XXXX. XXXX had a brief loss of consciousness and complained of neck pain, but denied arm pain, numbness, or tingling. XXXX thoracic and lumbar spines were non-tender and the neck was in a brace and was slightly tender. There were no step-offs. XXXX motor was normal and XXXX cranial nerve exam was non-focal. A cervical MRI dated XXXX was noted to show fractures at C2 and C3 with slight anterior tilt and displacement of the C2 odontoid process. There was no epidural hematoma or cord compression. A CT scan of the cervical spine dated XXXX was also reviewed and the impression was a C2 type 3 odontoid fracture with slight anterolisthesis. XXXX recommended a halo external orthosis for 3 months. XXXX then performed placement of halo ring and closed

reduction of C2 type 3 odontoid fracture on XXXX. XXXX then followed-up with the patient on XXXX and XXXX had some slight right sided neck pain, but was feeling better. XXXX were helping and XXXX denied arm numbness or tingling. XXXX medications were refilled and XXXX was asked to return in 6 weeks. As of XXXX, XXXX was doing much better, but had developed some back pain. XXXX denied any arm numbness or tingling. On occasion, XXXX did have headaches and noise was bothersome, as well, which XXXX noted was due to the closed head injury. XXXX was tolerating the halo and x-rays revealed maintained configuration of the C2 fracture, which was anterolisthesis of 3 mm. On XXXX, XXXX pain was better and XXXX still denied arm numbness and tingling. XXXX halo had migrated from the initial placement more cephalad and XXXX had some right sided swelling but not active draining or pus. XXXX motor exam was normal and XXXX anterior pins were loose in the anterior aspect. XXXX had some motion on flexion and extension, but not rotation. The CT scan revealed bridging across the fracture site, but it was not 100% healed. XXXX recommended a XX and a bone stimulator. On XXXX, the patient returned to XXXX and stated XXXX was feeling better. XXXX denied any arm numbness or tingling, but XXXX did complain of low back pain without leg pain. XXXX had been compliantly wearing XXXX brace. XXXX neck was non-tender and XXXX had reasonable range of motion (ROM). X-rays that day suggested the fracture was healed. Therapy was recommended at that time and XXXX was then evaluated on XXXX. Cervical flexion was 22 degrees, extension was 18 degrees, right side bending was 16 degrees, and left side bending was 8 degrees. Therapy was recommended 3 times a week for 6 weeks. Lumbar flexion was 50 degrees, extension was 10 degrees, as was left side bending, and right side bending was 12 degrees. SLR was 48 degrees on the right versus 40 on the left. Upper and lower extremity weakness was documented.

As of XXXX, the patient had attended 8 sessions and ROM was only slightly improved. XXXX also had upper and lower extremity weakness. SKR was now 34 degrees on the right versus 32 degrees on the left. Lumbar flexion had worsened. Nine additional sessions were recommended. As of XXXX, the patient had attended 5 additional sessions. Completion of the last 5 sessions was recommended. XXXX reexamined the patient on XXXX. XXXX still had decreased ROM side to side, which XXXX stated was not unusual. XXXX had no arm pain or weakness and it was noted XXXX was also doing therapy on XXXX lumbar spine. XXXX neck was non-tender and XXXX had good ROM in flexion and extension with lateral bending at 20 degrees. XXXX had a healed fracture at C2 with no instability on flexion and extension views, but XXXX did have some kyphosis fixed between C3 and C5 without anterolisthesis. XXXX recommended continued therapy, as well as a cervical MRI and TENS unit. As of XXXX, the patient had attended 24 total visits of therapy. XXXX had neck and low back pain and XXXX had difficulty moving XXXX neck. Reflexes were 2+ throughout, except the knees and the left upper extremity at 3+. Strength was 5/5 throughout. It was recommended that therapy be continued 3 times a week for 6 weeks. XXXX reevaluated the patient on XXXX and XXXX noted on occasion, XXXX got hand numbness. XXXX also had low back pain on the left and did not feel XXXX was ready to go back to work yet. SLR was negative and XXXX gait was normal. Cervical and lumbar MRIs were recommended, as well as additional therapy to include dry needling. On XXXX, a request was submitted for therapy 3 times a week for 6 weeks. On XXXX, XXXX requested 18 visits of physical therapy for the cervical and lumbar spines. On XXXX, XXXX provided a non-authorization for the requested physical therapy. Lumbar x-rays on XXXX revealed no osseous abnormality. An MRI revealed very mild central and left sided disc protrusion at L3-L4, but it was otherwise a normal study. A cervical MRI that day showed no significant disc disease or spinal canal stenosis. There was incomplete fusion of the C2 vertebrae with the odontoid process that was noted to likely be congenital in nature. There was

also a focal hemangioma involving the C3 vertebral body. On XXXX, XXXX provided another non-authorization for the requested physical therapy three times a week for six weeks. XXXX followed-up with the patient on XXXX and XXXX complained of persistent neck pain, but was improved overall. XXXX had occasional hand numbness, but had no upper extremity weakness. XXXX also had back pain after standing for prolonged periods of time and XXXX had done some water therapy in the past that helped. The MRIs were reviewed and cervical and lumbar ESIs were recommended, as well as continued therapy.

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

The patient has suffered a fracture of the odontoid with a compression fracture of C3. There is no objective evidence reviewed or provided of any injury or harm to the back. For a fracture of the cervical column without spinal cord injury the recommended treatment in the Official Disability Guidelines (ODG) is eight visits over 10 weeks, for cervicalgia (neck pain) the recommendation is nine visits over 10 weeks, and for a sprain/strain of the neck 10 visits over eight weeks are necessary. The patient clearly has exceeded this amount of therapy and the XXXX therapy evaluation, indicated XXXX had attended 24 sessions of therapy and had 3 remaining sessions. Furthermore, there is no objective evidence of any herniated disc, cord lesion, or other condition for which further therapy would be indicated. There is also no indication for further therapy in regards to the lumbar spine, given the lack of objective findings. Therefore, the requested physical therapy three times a week for six weeks is not reasonable, medically necessary, appropriate, or in accordance with the criteria and recommendations of the ODG. The previous adverse determinations should be upheld at this time.

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**

X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **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)**