CASEREVIEW
8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

**January 16, 2018**

**IRO CASE #:** XXXXX

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

Physical Therapy 6 sessions, 2 times a week for 3 weeks to treat the lower back area

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

This physician specializes in Physical Medicine and Rehabilitation and has 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 XX year old XXXX was injured on XXXXX when XXXX XXXXX. XXXX has a prior history of hurting XXXX back in a XXXXX. Diagnosis: Pain in thoracic spine, Dorsalgia and Cervicalgia

On XXXXX, the claimant presented to XXXXX, MPT, PT for an initial physical therapy evaluation. Major complaints were left low back pain with radiation into lower extremities, bending over to put shoes on, can't bend or lift, and difficulty sitting for long periods of time. Assessment/Diagnosis: Evaluation revealed left anterior pelvic rotation and sacral tilt which was believed to be contributing to XXXX chronic symptoms. Moderate tenderness T10 on right. Recommended PT to improve pelvic and sacral alignment to return to higher functioning levels. Plan: 2 times a week for 5 weeks. Treatment to be provided: Therapeutic Exercises, Neuromuscular Rehabilitation, Manual Therapy, Patient Education.

On XXXXX, the claimant presented to XXXXX, MPT, PT for a progress evaluation following 11 sessions of physical therapy. The claimant reported still felling pain on the left SI area and difficulty with prolonged standing and bending. Assessment/Diagnosis: Patient has attended 11 visits and has

made fair progress. Patient was very hypersensitive to mfr and testing so difficult to determine exactly what structures involved. Able to equalize pelvis but sacral tilt continues. Nutated due to anterior tilted pelvis, tight iliopsoas bilat worse on left than right. Emphasis on hip stabilizing in standing. Cervical pain c6 area and left thoracic area. Will continue to address as SI pain resolves. Recommend continued therapy to resolve SI pain and cx symptoms. Plan 2 times a week for 3 weeks.

On XXXXX, XXXXX, MD performed a UR. Rationale for Denial: With regard to Physical Therapy x 6, there was documentation of the claimant having diagnoses of pain in the thoracic spine, dorsalgia, cervicalgia, and myalgia and completed 13 physical therapy sessions to date, but there was no documentation detailing what specific progress was made from these therapy sessions and why additional therapy treatment is being requested including functional goals. Also the 13 therapy sessions completed already exceeds the guideline criteria as up to 10 therapy sessions are supported in the guidelines for this claimant's condition and additional therapy would be further in excess of the guidelines. Therefore, this request is non-certified.

On XXXXX, XXXXX, MD performed a UR. Rationale for Denial: It appears this patient has pain in the thoracic spine and was diagnosed with dorsalgia. The patient has been sent to physical therapy and has already completed 13 sessions of therapy. An additional 6 sessions are being requested as the patient has not yet reached the goal of "0/10" pain. ODG supports up to 10 visits for Thoracic sprains. This patient has already completed 13 sessions. At this point, the patient should have been given a home exercise program and should be able to begin a home-based exercise program. The submitted notes do not indicate why this patient cannot participate in a home-based program after completing 13 sessions of physical therapy. As such, this request for an additional 6 sessions of physical therapy after having already completed 13 prior sessions is not appropriate as it exceeds treatment guidelines and a non-certification is recommended.

On XXXXX, XXXX. XXXXX wrote a Letter of Appeal. In the letter XXXX does indicate XXXX is doing all XXXX exercises and stretches taught thus far every night. XXXX also stated XXXX symptoms were returning, including headaches and severe pain through XXXX back and legs.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
Determination: denial of 6 Physical Therapy sessions, 2 times a week for 3 weeks, to treat the lower back is UPHELD/AGREED UPON since the request exceeds ODG recommended number of visits and time frame for the submitted diagnoses with a report of completion of 13 PT visits since the injury xxxxx and report of instruction in and daily compliance with an independent home exercise program. Furthermore, there is lack of documentation of any prior diagnostic studies and concomitant treatment including any medication and activity modification. There is question as to consideration of further diagnostic studies, invasive procedures, and/or progression to more functional rehabilitation programs.

**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
**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

*ODG Physical Therapy Guidelines –*
Allow for fading of treatment frequency (from up to 3 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.
**Myalgia and myositis, unspecified**:
9-10 visits over 8 weeks
**Neuralgia, neuritis, and radiculitis, unspecified**:
8-10 visits over 4 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)**