US Decisions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

Patient Name:	XXX	***Case Number:***	XXX
Review Type:	Preauthorization	***Date of Notice:***	XXX
Coverage Type:	Workers' Compensation	***IRO Certification No.:***	XXX

Review Outcome

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

Licensed Chiropractor

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 is a XX, XX who was diagnosed with post laminectomy syndrome, not elsewhere classified (M96.1).

On XX, XX was seen by XX, DC where XX reported that XX lower back pain was improving tremendously with the post-surgical physical therapy. XX was experiencing an increase in sensory at XX right lower extremity. XX was also able to increase XX activities of daily living; however, XX had tenderness and radiating symptoms down to XX right lower extremity. XX reported numbness and tingling at the bottom of the right foot and little toe. XX was scheduled to follow-up with XX on XX. XX continued to have sharp tenderness at XX right knee joint, and there was tenderness noted at XX left shoulder and right ankle joints with pain rated at 5/10. XX was also scheduled to follow-up with XX for pain management on XX. An individual psychotherapy evaluation was pending at the time and additional post-surgical physical therapy sessions were also pending at the time. The examination showed numbness and tingling at the right lower extremity along the S1 dermatomal distribution. Lumbar spine range of motion was decreased with flexion 31 degrees, extension 15 degrees, right lateral flexion 18 degrees and left lateral flexion 19 degrees. Tenderness was also noted at the lumbar spine upon palpation. Tenderness and spasm were noted at the lumbar paraspinal musculature bilaterally upon palpation. A decrease in deep tendon reflexes was noted at the lower extremity at +1/2. There was an improvement in muscle strength at the right lower extremity; however, weakness was present. Sharp tenderness was noted at the right knee joint upon palpation. A decrease in right knee range of motion was noted with flexion 128 degrees and extension 0 degrees. Muscle strength was decreased in the right lower extremity. Tenderness was also noted at the left shoulder joint upon palpation. There was a decreased range of motion at the left shoulder joint with flexion 126 degrees, extension 24 degrees, abduction 130 degrees, adduction 26 degrees, internal rotation 44 degrees, and external rotation 45 degrees. A decrease in muscle strength was noted at the left upper extremity. There was a decreased range of motion noted at the right ankle with plantarflexion 18 degrees, dorsiflexion 19 degrees, inversion 14 degrees, and eversion 16 degrees. Tenderness was noted at the right ankle joint

upon palpation. Muscle weakness was continued. There was numbness and tingling noted along the S1 dermatomal distribution. An orthopedic evaluation, straight leg raise, Kemp test, shoulder depression test and heels / toes walk test were positive.

An MRI of the lumbar spine dated XX, revealed moderate disc narrowing, loss of normal signal, posterior central, right paracentral protruded herniated measuring 3.72 mm with slight thecal sac impingement, inferior sub-ligamentous migration at L4-L5. Disc narrowing, loss of normal signal, posterior central, right paracentral herniated disc measuring 5.26 mm with suggestion of focal extrusion and inferior migration with thecal sac impingement adjacent to right S1 nerve root.

X-rays of the lumbar spine dated XX, showed disc narrowing at L4-L5 without evidence of spondylosis or spondylolisthesis.

X-rays of the right knee dated XX, demonstrated mild-to-moderate medial space narrowing without evidence of joint effusion or fracture.

Treatment to date consisted of medications, physical therapy, and surgical intervention (right L5-S1 hemilaminectomy for excision of a herniated nucleus pulposus and anion tissue graft).

Per letters of medical necessity by XX, dated XX and XX, XX was under care for work-related injury that had occurred on XX. sustained injury to XX lower back area. XX had lumbar surgery on XX for lumbar laminectomy with XX. XX had completed 16 sessions of postsurgical physical therapy. XX showed tremendous amount of improvement with an increase in muscle strength, range of motion, sensory, endurance, stamina and decreased tenderness, numbness and tingling. However, upon XX most recent follow-up, XX was exhibiting a less-than-favorable condition. A decrease in range of motion at the lumbar spine was noted. Tenderness at the lumbar paraspinal musculature was noted bilaterally upon palpation. There was continued radiating numbness down to XX right lower extremity along the S1 dermatomal distribution. Muscle weakness was noted at the right lower extremity. A decrease in deep tendon reflexes was noted at +1/2. Therefore XX requested for additional 12 postsurgical physical therapy sessions to help restore XX functional deficit. XX strongly believed that XX would benefit greatly from the additional post-surgical physical therapy sessions and would make a tremendous amount of improvement.

Per a utilization review determination letter dated XX, the request for additional 12 visits over six weeks of physical therapy for the lower back was noncertified. It was determined that XX reported improvement initially with physical therapy; however, on XX latest examination on XX, XX was found to have a decrease in range of motion of the lumbar spine, tenderness along the lumbar spine musculature, decreased deep tendon reflexes, radiating numbness down XX right lower extremity along the S1 dermatome and muscle weakness of the right lower extremity. Those symptoms appeared to not to have changed since XX examination dated XX, prior to the previous therapy sessions. The additional physical therapy visits also exceeded the recommended visits, and there was no medical justification or exceptional factors for more physical therapy sessions when XX had neurological symptoms, and the documentation did not show any improvement in XX range of motion and strength from the previous physical therapy. Official Disability Guidelines (ODG) recommended 16 visits over eight weeks for postsurgical treatment of laminectomy. When the number of treatment visits exceeded the guidelines, then exceptional factors should be noted. Per the discussion with XX ,XX, XX had continued restricted range of motion even though after four months of surgery. A simple laminectomy should not cause any significant motion restriction at the time. The postoperative number of physical therapy visits had already been met and ODG recommended only eight weeks of therapy, which had been about 16 weeks or more since surgery. The request did not meet Guidelines criteria; therefore, the request for 12 additional physical therapy visits was denied.

A utilization review letter dated XX indicated that the reconsideration request (appeal) was reviewed and the original noncertification determination was upheld. Rationale: “The provider indicated that the injured worker is status post lumbar laminectomy and completed 16 postoperative physical therapy visits .XX has continued pain as well as range of motion and strength deficits and the additional postoperative therapy treatment is being requested for further functional improvement and decreased pain. However, the 16 postoperative therapy visits completed is the maximum amount recommended in the guideline criteria for the type of surgery done, and the additional therapy being requested would be well in excess of the guidelines and with continued pain and functional deficits still present and no indication of a return back to work that had occurred. It appears that the previous physical therapy treatment did not help much, and the injured worker has plateaued from the therapy treatment, and therefore, additional physical therapy will not be of added functional benefit, and this request is non-certified.”

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Case Number :XXX Date of Notice: 07/05/18

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 for Post-surgical physical therapy for the lumbar spine, two times per week for eight weeks, 97112 - Therapeutic procedure, 1 or more areas, each 15 minutes, 97140 - Physical Medicine and Rehabilitation Therapeutic Procedures, 97530 - Physical Medicine and Rehabilitation Therapeutic Procedures, 97535 - Physical Medicine and Rehabilitation Therapeutic Procedures, 97035 - Application of a modality to 1 or more areas, 97110 - Therapeutic procedure, 1 or more areas, each 15 minutes is not recommended as medically necessary and previous denials are upheld. The patient underwent right hemi-laminectomy L5-S1 on XX and has completed at least 16 postoperative physical therapy visits to date. Current evidence based guidelines support up to 16 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. 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. Given the documentation available, the requested service(s) is considered not medically necessary.

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
- ☐ 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
- ☐ Intergral 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

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

☐ 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.