AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 3, 2018

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy 2-3 times a week for 8 weeks (thoracic and lumbar spine)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Rehabilitation and Physical Medicine with over 15 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]:
XX: Physical Therapy Prescription dictated by XX, MD. Evaluate and treat 3xwk x 6 weeks; XX only. DX: work related injury, back pain.

XX: Re-Evaluation dictated by XX PT. DX: low back pain. RX: Prxs for XX ex and patient education. VAS 4/10. CC: pain in area of RT ribs, no current low back pain, reported feels a pinch occasionally when XX low back is arched. Claimant has been educated on posterior pelvic tilt with no radicular sx's. 47% disability (regressed due to rib pain). ROM: normal flexion 75%, RT SB 50%, LT SB 50%, extension 25%. Mild hip flexor tightness. Goals: The claimant will demonstrate improved outcomes tool by 50% (not met); other goals marked as met. Plan: Completed XX, worker's comp approved 12 only. Will send reevaluation to get remaining 6x authorized.

XX: New Patient Evaluation dictated by XX, MD. CC: back pain. HPI: complained of having severe back pain radiating across the right ribs. There is also left arm pain with numbness, tingling and weakness down arm and fingers. Pain began on XX when XX slipped on XX, XX, XX while on a XX XX, XX XX. Evaluation revealed L1 and L2 transverse process fracture, narrowing of the disk space and T8 and T9 disk protrusion. Claimant had physical therapy in XX with no relief; currently taking XX as needed. Claimant tried XX with no relief and with side effects. Location: back and left arm symptoms that are aching, throbbing and tingling in nature and with spasms and numbness. Claimant reported not being able to fall sleep due to pain and wakes up in the middle of the night due to pain; constant. Minimal activity and rest are the only things reported to alleviate pain and aggravated by pushing, lifting and walking. Previous treatments include heat, cold, medications, physical therapy, home exercises and TENS unit. VAS 5/10, best 3/10 and worst 8/10. PE: Back: pain with palpation of thoracic spine, extension elicits right low back pain, lumbar flexion elicits in low back

and right ribs. Assessment and Diagnosis: Thoracic back pain, Intercostal pain, Herniated thoracic nucleus pulposus, Lumbar herniated nucleus pulposus, Fracture of transverse process of lumbar vertebra, Lumbago, Myofascial pain syndrome lumbar and thoracic, cervical radiculopathy, and thoracic radiculopathy. Schedule Right T10-11 interlaminar ESI under fluoroscopic guidance with anesthesia; consider L1-2 facet injections. UDS for compliance monitoring, Cervical Spine MRI for left arm symptoms, RTC 1 month.

XX: Request for Service dictated by XX, MD. M54.5 low back pain. Patient to be treated by lower back physical therapy as per therapist direction.

XX: Physical Therapy Initial Examination dictated by XX, MD. CC: thoracolumbar pain and its associated radiating pain began approx. 1 year prior when XX was injured on the job. More recently, XX has started to feel pain in XX cervical spine with radiating pain into XX L UE. Thoracolumbar pain with radiating pain into lower ribs and L UE leading to an overall decline in function. Before, no limitations. Current Functional Limitations: Claimant has pain and difficulty with sitting, lifting heavy objects, sleeping, general work duties, twisting and rotating, bending, and bed mobility. 46% disability. XX presenting to PT evaluation with impaired resting posture including asymmetrical shoulder and pelvic height. XX has forward head posture and rounded shoulders. XX thoracolumbar paraspinals have notable mass and tine typically found in back pain. XX was very fidgety during eval, having to stand and sit several times due to the discomfort from staying in one position for too long. XX trunk ROM is severely impaired. Claimant is a good candidate for skilled services to address XX impairments and return to PLOF. Plan: 2-3 times a week x 8 week.

XX: UR performed by XX, MD. Reason for denial: Guidelines allow for up to 9-10 sessions of PT for XX condition. XX has already exceeded guideline recommendations. The records indicate that the claimant has completed at least 12 sessions of PT. Any further functional gains should be obtained in an independent HEP consisting of stretching, strengthening and ROM exercises whish the claimant should be capable of performing, given the number of therapy sessions that the claimant has attended. Additional supervised therapy significantly exceeding guideline recommendations is not supported over a HEP. Therefore, my recommendation is to non-certify the request for PT 2-3 x/week for 8 weeks.

XX: UR performed by XX MD. Reason for denial: The low back chapter of the ODG regarding PT states, "Recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain… 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 self0directed home PT… Lumbago; backache, unspecified: 9 visits over 8 weeks". On XX, request was non-certified. Per the rationale, the guidelines allowed for up to 9-10 sessions of PT for XX condition, and XX had already exceeded guideline recommendations. The records indicated that XX had completed at least 12 sessions of PT. Any further functional gains should be obtained in an independent HEP consisting of stretching, strengthening and ROM exercises which XX should be capable of performing, given the number of therapy sessions that XX had attended. Additional supervised therapy significantly exceeding guideline recommendations was not supported over a HEP. Currently, it is noted that the claimant had already completed about 12 PT sessions, which exceeds the ODG guidelines for treatment of non-specific low back pain. There were no documented extenuating circumstances to support an exception to the guidelines. The claimant should be able to make a transition to self-led home exercise. Therefore, PT is not shown to be medically necessary and is non-certified; thus, the appeal is upheld.

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

Denial of additional PT visits 2 to 3 times a week for 8 weeks to the thoracic and lumbar spine is UPHELD/AGREED UPON since the request exceeds ODG recommended number of visits and time frame for submitted diagnoses, and clinically after completion of 12 PT visits nearly one year ago there is no documented progress in pain level, range of motion, strength, or function, and documentation of instruction in and compliance with a home exercise program. Furthermore, there is question regarding consideration of invasive procedures, and/or consideration of progression to more aggressive, functional rehabilitation programs. After reviewing the medical records and documentation provided, medical necessity cannot be established for the

service requested and therefore the request for Physical Therapy 2-3 times a week for 8 weeks (thoracic and lumbar spine) is denied.

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)**