MEDRx

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Notice of Independent Review Decision

DATE OF REVIEW: June 18, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Additional physical therapy-10 sessions (lumbar spine)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopaedic Surgery.

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

☒Upheld (Agree)

☐Overturned (Disagree)

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

The reviewer agrees with the previous adverse determination regarding the medical necessity of: additional physical therapy-10 sessions (lumbar spine)

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient is a XX who sustained an XX injury on XX. The mechanism of injury was described as a XX. XX sustained a closed unstable burst fracture of L3 and closed compression fracture of L1 and underwent T11-L4 pedicle screw fixation on XX. XX was also diagnosed with a mesenteric tear and a portion of XX bowel was resected. XX was diagnosed with a chronic left upper extremity deep vein thrombosis and underwent inferior vena cava filter placement on XX, and subsequent removal on XX. The XX physical therapy re-evaluation report indicated that the patient had completed 37 sessions of

physical therapy. Current complaints included grade 1/10 pain before treatment and grade 1/10 pain after treatment. XX initially reported significant left leg neural symptoms which had mostly resolved with some residual tingling and some slight weakness. XX reported being compliant with XX home exercise program. Oswestry score was 20% (minimal disability), improved from 24% on XX, 36% on XX, 32% on XX, and 30% on XX. Manual muscle testing documented 4+/5 right and 4/5 left gluteal maximus and psoas strength, and 4+/5 bilateral gluteus medius strength. Single stance was 30 seconds bilaterally. The diagnosis included lumbar burst fracture with routine healing, acute bilateral low back pain with left sided sciatica, left hip weakness, and gait abnormality. Current goals not met included a reduced modified Oswestry Score at minimum 50% points of initial rating to demonstrate improved functioning and reduction in patient perceived disability, and improvement in gluteus medius and maximus strength to 4+/5. The treatment plan recommended one session per week to every other week, 12 sessions. It was noted that the patient would benefit from continued skilled physical therapy services to address continued deficits in efforts to continue functional restoration, improve cardiovascular/aerobic endurance, and return to work. The patient completed 3 additional physical therapy sessions as of XX with grade 3/10 pain before treatment and grade 1/10 pain after treatment. Was able to tolerate increased demand of the cardiovascular system via increased cycle resistance in additional to sustained moderate to high level intensity. The importance of compliance with home exercise program was reiterated. The XX utilization review non-certified the request for 10 additional physical therapy sessions for the lumbar spine. The rationale stated that the patient had completed at least 40 sessions of physical therapy to date and there was no significant subjective or objective findings on the most recent physical therapy evaluations to warrant additional supervised physical therapy over transition to a home exercise program. The XX utilization review non-certified the appeal request for additional physical therapy 10 sessions for the lumbar spine. The rationale stated that there was insufficient information to support a change in determination. There was no clinical evidence to suggest that additional skilled physical therapy would be any more beneficial than performance of a home exercise program to address any remaining objective functional deficits. It was noted that the patient should be well-versed in an independent exercise program by now considering the amount of therapy that had been completed.

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

The prospective request for additional physical therapy-10 sessions (lumbar spine) is not medically necessary. The denial is upheld.

The Official Disability Guidelines recommend physical therapy for 34 visits over 16 weeks for patients with vertebral column fractures without spinal cord injury.

This patient sustained severe traumatic injuries in a XX accident on XX. had an L3 burst fracture and L1 compression fracture requiring surgical fixation from T11 to L4. has mild residual lumbar pain; most recently grade 1-3/10. XX initial neurologic symptoms have mostly resolved with some residual left lower extremity tingling and slight weakness. XX current Oswestry Disability Index Score is 20% (minimal disability), improved from 24% on XX. There is current 4/5 left gluteal maximus and psoas weakness. XX has improving cardiovascular endurance. XX has completed 40 visits of physical therapy as of XX, and 10 additional sessions have been requested. The Official Disability Guidelines recommend up to 34 visits in this clinical setting. The current functional inventory score does not support additional treatment, and there is not significant improvement in the functional inventory score documented since XX. The residual left hip weakness could be addressed in XX independent home exercise program. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of additional supervised physical therapy as an exception to guidelines. Therefore, this prospective request for 10 additional physical therapy sessions for the lumbar spine is not medically necessary.

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**
ODG Treatment
Integrated Treatment/Disability Duration Guidelines
Low Back-Lumbar & Thoracic (Acute & Chronic)
(Updated 5/4/18)
Physical therapy (PT)

☐ **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)**