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One Sansome Street, Suite 600
San Francisco, CA 94104-4448

415.677.2000 Phone
415.677.2195 Fax
www.lumetra.com

DATE OF REVIEW: 08-06-2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 Sessions of Physical Therapy

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

Doctor of Chiropractic

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)

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/NDC	Upheld/ Overturn
xx/xx/xx	xxxxxxx	Prospective	722.10	97110	Upheld
xx/xx/xx	Xxxxxxx	Prospective	728.85	97140	Upheld

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notices of Adverse Determination (05-04-07 & 07-19-07)
Letters dated 02-09-07 and 06-02-07
Physician Evaluations (01-30-07, 04-27-07)
Care Evaluation (04-05-07)
Therapy Evaluation (04-11-07)

PATIENT CLINICAL HISTORY:

This patient was injured on xx/xx/xx while lifting buffers from a truck. Low back pain and lower extremity pain is reported as a result of the injury.

According to the documentation in the 1/30/2007 examination, a MRI of the lumbar spine performed on 6/9/2006 reported multi-level degenerative changes in the lumbar region with Schmorl's nodes, a small right lateral disc herniation at L2-3, and mild canal narrowing at L4-5. The patient was evaluated in June 2006, and Impressions were Right L2-3 Disc Protrusion, L4-5 Disc Disease, and Left SI Joint Pain.

During the evaluation of 1/30/2007, pain was reported in the low back and left leg and occasionally in the right leg. Examination reported paravertebral tenderness with no significant spasm or trigger points. Range of motion was reported as limited in extension. Neurological testing including muscle strength testing was unremarkable. The opinion was that the patient had not reached MMI.

The examination of 4/5/2007 documents normal gait and posture, full range of motion without pain, but also reports mild decreased lateral flexion and mild tenderness to palpation. The patient was diagnosed with Lumbo Sacral Strain and Lumbar Disc Herniation.

Physical therapy examination of 4/11/2007 notes that the patient presented with low back and right lower extremity pain. Examination reported forward flexion limited by 66%, extension by 33%, and lateral flexion by 50%. Straight leg was reported to increase low back pain. Neurological testing was unremarkable. Treatment plan was for daily care for one week followed by treatment 3 times per week for 4 weeks.

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On the evaluation of 4/27/2007, pain was reported as an 8 on a 1-10 scale. Also noted was tingling in his right gluteal region and discomfort down his right leg to his foot. Examination reported range of motion that was limited in flexion and left lateral flexion by ~50%. All other planes of motion were limited by 60% or greater. Reflexes were reported as diminished on the right. Sensory testing reported as decreased in the L5-S1 dermatome on the right, and motor testing reported weakness in the extensor hallucis longus and in the gastroc soleus. Straight leg raise was reported as positive on the right at 30° and on the left at 50°. Both were reported to cause low back and right leg pain. Kemp's and Valsalva's were reported as positive on the right. The patient was diagnosed with Radiculitis, Lumbar Disc Displacement, Muscle Spasm, and Muscle Pain.

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

As much as the MRI revealed a small disc bulge at L2-3 and mild canal narrowing at L5-S1, there is no evidence of impingement of the spinal cord or existing spinal nerves. Hence in the absence of such finding the claims of radicular pain as being neurological in nature lack reasonable clinical support. Furthermore the findings of the 4/27/2007 examination of decreased deep tendon reflexes, sensory findings, and muscle weakness are the first report of any positive neurological findings in the prior year of treatment.

In the absence of more meaningful medical records and objective findings, additional or prolonged chiropractic care and physical therapy cannot be considered reasonable or necessary. ACOEM Guidelines (pg. 43-45, 90-92, 113-115, 166, 174, 175, 182, 188, 299-301, 315) and the Official Disability Guidelines, 10th edition, state that if an individual's progress is not in relation to the extent or duration of the chiropractic or physical therapy services provided to achieve such progress or restoration, then those services are not considered reasonable or necessary. In light of this injury as now more than one year old, the frequency and duration of the treatment plan proposed cannot be supported. ACOEM Guidelines (pg. 43, 49, 83, 92) also state that objective functional improvement is essential to establishing reasonableness and necessity of care and that the goal of treatment should be the establishing of self-directed care and maximizing activity tolerance. These objectives have been shown to reduce somatization and physician dependence.

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Any benefit that was achieved through the course of therapy rendered has long since been realized, and continued care of this manner cannot be considered a reasonable means by which to cure or relieve the patient's condition.

With respect to ongoing treatment of low back with manipulation, ACOEM Guidelines Chapter 12 reports the following on the ongoing use of this form of treatment.

- Manipulation appears safe and effective in the first few weeks of back pain without radiculopathy. Of note is that most studies of manipulation have compared it with interventions other than therapeutic exercise, hence its value as compared with active, rather than passive, therapeutic options is unclear. Nonetheless, in the acute phases of injury, manipulation may enhance patient mobilization. If manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated. For patients with symptoms lasting longer than one month, manipulation is probably safe but efficacy has not been proved.
- ODG Guidelines also report that though chiropractic care for the low back is an option, it generally is most effective in the first weeks of care. Chiropractic care for chronic cases is not proven by multiple high quality studies.
- ODG Guidelines also state that manipulation is recommended as an option. Medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. For patients with chronic low back pain, manipulation may be safe and outcomes may be good, but the studies are not quite as convincing. While not proven by multiple high quality studies, a trial of manipulation for patients with radiculopathy may also be an option, when radiculopathy is not progressive, and studies support its safety. As with any conservative intervention in the absence of definitive high quality evidence, careful attention to patient response to treatment is critical. Many passive and palliative interventions can provide relief in the short term but may risk treatment dependence without meaningful long-term benefit. Such interventions should be utilized to the extent they are aimed at facilitating return to normal functional activities, particularly work.

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It is evident from these guidelines that any benefit for this industrial injury that spinal manipulation provided has long since passed, and any ongoing care by these means cannot be considered reasonable or necessary as a means to cure or relieve the injury of xx/xx/xx.

With respect to treatment with physical therapy modalities, ACOEM Guidelines Chapter 12 reports the following.

- There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neuro-stimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living.
- The Philadelphia Panel on EBCPG (Evidence Based Clinical Practice Guideline) conducted an exhaustive search of the literature and found little to no benefit from the use of passive modalities such as electrical muscle stimulation, massage and ultrasound.

In light of the above Guidelines, any benefit that may have been derived by treatment with these passive modalities has long since passed, and any ongoing care by these means cannot be considered reasonable or necessary.

Lumetra's Physician Reviewer has no known conflicts of interest in this case, pursuant to the Insurance Code Article 21.58A (Chapter 4201 effective April 1, 2007), Labor Code § 413.032, and §12.203 of this title.

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)**