



5068 West Plano Parkway Suite 122
 Plano, Texas 75093
 Phone: (972) 931-5100
 Fax: (888) UMD-82TX (888-863-8289)

DATE OF REVIEW: AUGUST 26, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Nine sessions of physical therapy

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

Doctor of Chiropractic, licensed in the State of Texas, and DWC ADL approved.

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)

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Nine sessions of physical therapy	97112, 97110, 97140	Upon approval	Adverse determination upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Record Description	Record Date
Lumbar X-rays –MD	09/21/05
MRI Examination of lumbar –MD	10/05/05
EMG & NCV study –MD	10/11/05
Lumbar & Spine X-rays –Hospital	03/14/06
MRI Examination of lumbar –	05/08/06
MRI Examination of lumbar –MD	08/03/06
Chart notes –MD	03/06/06 05/07/06 09/21/06 11/20/06 01/25/07
EMG & NCV study –MD	09/21/06
Discogram & Post Discogram CT lumbar & Consultation –MD -	01/25/07
Physical Performance test /Exam 2 –Inc	05/29/07

Physical Performance test /Exam 2 –Inc	07/02/07
UR decision for physical therapy –Inc.	07/16/07
Physician Peer Review (requested by Dr.) –	07/20/07
UR appeal decision for physical therapy –Inc.	07/23/07
Request for IRO, ODG guideline information	08/09/07
Letter of Medical Necessity – Dr.	08/21/07

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the records, the claimant injured his lower back. The claimant underwent lumbar spinal fusion. Subsequently, the claimant underwent and completed 24 sessions of post-operative physical therapy (rehabilitation) of the lumbar spine. There are two FCEs noted that were performed, one in May and one in July, indicating improvement according to Dr., but there are questions of validity that Dr. report brought up regarding the results of the two FCEs with the claimant not giving maximum effort. Dr. has indicated the claimant has improved from May to July from a sedentary/light PDL to a light/medium PDL in July. After reviewing the two FCE's there are some issues of validity as well as minimal improvement in objective testing. However, the amount of improvement is so minimal those findings could have easily been skewed. Finally, Dr. has requested an additional 9 sessions of physical therapy to the lumbar spine, but was denied due to lack of improvement.

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

It is apparent; Dr. is requesting additional rehabilitation sessions because the guidelines allow up to 34 sessions, not based on evidence based medicine, necessity and or objective results. The submitted records indicate a stable chronic condition without substantial improvement between the first FCE and the second FCE. The goals of the FCE are to establish improvement with the end results of achieving the claimant to return to work. The minimal improvement between the FCEs does not meet the overall goal of returning this claimant back to work. As noted in the History section of this report, the two FCEs that were performed, one in May and one in July, indicate improvement according to Dr., but it is very minimal improvement at best. However, the questions of validity that Dr. report brought up regarding the results of the two FCE performed with the claimant not giving maximum effort is also true and should invalidate the FCEs. The claimant has received 24 visits of post-operative rehabilitation without substantial objective documentation of improvement. The requested additional rehabilitation is not supported by Dr. report/letter, nor by the guidelines as indicated above to meet the requirements of medical necessity. Therefore, the denial for the request of additional sessions of rehabilitation is upheld. Based upon evidence based medicine from the information provided suggests the requested procedures are not medically necessary.

DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG:

According to ACOEM guidelines and recent reviewed articles all encourage and support the use of home exercise programs. They suggest a home exercise program with one or two visits with a good physical therapist to evaluate, educate, and council patients (Daskapan 2005) (Ashworth 2005) Ashworth concluded, "home based programs appear to be superior to center based programs in terms of the adherence to exercise (especially in the long-term)". According to ODG guidelines, there is strong evidence that exercise reduces disability duration in employees with low back pain (ODG-TWC Low back page 13). A spinal stabilization program (exercises that emphasize strengthening of varioius muscles supporting the spine) is more effective than standard physical therapy sessions in which no exercises are prescribed. Manual therapy may be appropriate as a pain reducing modality, but it should not be used as an isolated modality because it does not reduce disability. (Goldby-Spine, 2006). The ODG guides Low Back under flexibility section indicate not recommended as a primary criteria, but they should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. This has implications for clinical practice as it relates to disability determination for patients with chronic low back pain, and perhaps for the current impairment guidelines of the American Medical Association. (Parks, 2003) (Airaksinen, 2006) The value of the sit-and-reach test as an indicator of

previous back discomfort is questionable. (Grenier, 2003) The AMA Guides to the Evaluation of Permanent Impairment, 5th edition, state, "an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way" (p 400). They do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. (Andersson, 2000) See also Stretching. The ACOEM guidelines states on page 288, " The strongest medical evidence regarding potential therapies for low back pain indicates that having the patient return to normal activities has the best long term outcome. Many invasive and noninvasive therapies are intended to cure the pain, but no strong evidence exists that they accomplish this as successfully as therapies that focus on restoring functional ability without focusing on the pain. In these cases, the traditional medical model of "curing" the patient does not work well. Furthermore, the patient should be aware that returning to normal activities most often aids recovery. Patients should be encouraged to accept responsibility for their recovery rather than expecting the provider to provide an easy "cure." This process will promote using activity rather than pain as a guide, and it will make the treatment goal of return to work more obvious in the occupational setting." The ACOEM guidelines do indicate, once the claimant has recovered, a progressive return to normal work activities... continue to encourage dialy exercise to maximize work activity tolerance and reduce recurrence. This has been accomplished thoroughly as noted in the records. Furthermore, the ACOEM guidelines Chapter 5, indicated "Prompt return to work in a capacity suitable for the worker's current capabilities and needs for rest, treatment, and social support prevents deconditioning and disabling inactivity, reinforces self esteem, reduces disability, and improves the therapeutic outcome in most individual cases and on an aggregate basis. Ill or injured workers can be temporarily placed in different jobs from their usual jobs (temporary duty), or their usual jobs can be temporarily modified to accommodate their limitations and remaining abilities (modified or temporary transitional work). Accommodation, with progressively fewer restrictions as healing occurs, generally has a greater chance of success; the highest success rates are achieved when workers return to a modification of their pre injury job. Disability management conveys respect for injured or ill employees and provides social support that hastens recovery"; "In order for an injured worker to stay at or return successfully to work, he or she must be physically able to perform some necessary job duties. This does not necessarily mean that the worker has fully recovered from the injury, or is pain free; it means that the worker has sufficient capacity to safely perform some job duties. Known as functional recovery, this concept defines the point at which the worker has regained specific physical functions necessary for re employment." Also, under the ODG "Fitness for Duty" for FCEs the guides state: Both job-specific and comprehensive FCEs can be valuable tools in clinical decision-making for the injured worker; however, FCE is an extremely complex and multifaceted process. Little is known about the reliability and validity of these tests and more research is needed. (Lechner, 2002) (Harten, 1998) (Malzahn, 1996) (Tramposh, 1992) (Isernhagen, 1999) (Wyman, 1999) Functional capacity evaluation (FCE), as an objective resource for disability managers, is an invaluable tool in the return to work process. (Lyth, 2001) There are controversial issues such as assessment of endurance and inconsistent or sub-maximum effort. (Schultz-Johnson, 2002) Little to moderate correlation was observed between the self-report and the Isernhagen Work Systems Functional Capacity Evaluation (FCE) measures. (Reneman, 2002) Inconsistencies in subjects' performance across sessions were the greatest source of FCE measurement variability. Overall, however, test-retest reliability was good and reliability was excellent. (Gross, 2002) FCE substests of lifting were related to RTW and RTW level for people with work-related chronic symptoms. Grip force was not related to RTW. (Matheson, 2002) Scientific evidence on validity and reliability is limited so far. An FCE is time-consuming and cannot be recommended as a routine evaluation. (Rivier, 2001) Isernhagen's Functional Capacity Evaluation (FCE) system has increasingly come into use over the last few years. (Kaiser, 2000) Ten well-known FCE systems are analyzed -- All FCE suppliers need to validate and refine their systems. (King, 1998) Compared with patients who gave maximal effort during the FCE, patients who did not exert maximal effort reported significantly more anxiety and self-reported disability, and reported lower expectations for both their FCE performance and for returning to work. There was also a trend for these patients to report more depressive symptomatology. (Kaplan, 1996) Safety reliability was high, indicating that therapists can accurately judge safe lifting methods during FCE. (Smith, 1994).

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: the Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 05/01/2007.