5068 West Plano Parkway Suite 122
Plano, Texas 75093
Phone: (972) 931-5100

DATE OF REVIEW: 12/06/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions of physical therapy - 3 times a week for 4 weeks

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

This case was reviewed by a Texas licensed DC, specializing in Chiropractic.

REVIEW OUTCOME:

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

☒ Partially Overturned

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
12 sessions of physical therapy - 3 times a week for 4 weeks	97139, 98941, 97110, 97112, 97250, 97530	Upon approval	Partially Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Documentation:	Date:
Functional Capacity Exam –Healthcare Associates	09/04/07
Utilization Review Request – 12 sessions of physical therapy –Healthcare	09/05/07
Consultation Office Visit –MD Anesthesia Back Pain Center	09/11/07
Utilization Review – Adverse determination 12 sessions physical therapy – ODG Decision criteria and source cited –	09/12/07
MRI Cervical & Lumbar – Diagnostic Center	09/26/07
Utilization Review Appeal Request – 12 sessions of physical therapy –Healthcare	09/25/07
Utilization Review – Approval of 6 visits of physical therapy –	10/01/07
Case Report – Referral for review of 12 visits of PT	10/01/07
Re-Exam Narrative Report –DC	10/12/07
Utilization Review Request – 12 sessions of physical therapy –Healthcare	10/12/07
Initial Concurrent Review – Assess medical necessity of 12 sessions of PT - America	10/18/07
Utilization Review – Adverse determination 12 sessions physical therapy – ODG Decision criteria and source cited –	10/19/07
Utilization Review Appeal –DC Healthcare	10/31/07

Utilization Review Appeal – Adverse determination 12 sessions physical therapy – ODG Decision criteria cited but source criteria not included –	11/05/07
Appeal Prospective Review – Assess medical necessity of 12 sessions of physical therapy –	11/05/07
Re-Exam Narrative Report - progress FCE–DC	11/09/07
Letter regarding IRO request –	11/19/07

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the records, the claimant injured his neck, mid back and lower back. Apparently, the claimant lifted a heavy object (60 lb) and lost his balance and bent backwards over a railing. He sought care with the company doctor who prescribed medications. Approximately 4 days later the claimant sought care with Dr. who examined him and began passive therapy for 2 weeks completing 6 visits. On 09-04-07, an FCE was performed with questionable outcomes for a man his size and his occupational requirements. On 09-26-07, MRI's of the cervical and lumbar spinal regions indicated a chronic degenerative process without neural root compromise, but does indicate stenosis due to the chronic degenerative. On 11-02-07, he underwent a lumbar ESI which the records indicate he responded well with decreased pain and increased function. Now, Dr. would like to continue care at 3 times a week for 4 weeks.

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

It is apparent, the claimant has undergone 6 total visits of care which were passive and Dr. appears to be attempting to move to a more aggressive active physical therapy course that the guides support. The guides indicate a progression into active therapy is more appropriate with manipulation than without manipulation.

Although, the guides indicate a lower amount of treatment for a sprain/strain in the cervical and lumbar spinal regions, it does not take into consideration the complicating factors such as the severity of the degenerative process in the cervical and lumbar regions. Looking at the entire case presentation, it is obvious the claimant has complicating factors that will limit his response to treatment however, an additional 12 visits of active therapy with manipulation is not unreasonable. The submitted records indicate a chronic condition that a traumatic event super-imposed upon. The requested additional sessions of active therapy is supported by the guidelines as improvement has been documented as indicated in the data supplied by the treating physician, which meets the requirements of medical necessity.

Therefore, the denial for the request of 12 additional sessions of therapy is partially over-turned. Based upon evidence based medicine from the information provided, the requested procedures are partially medically necessary, reasonable and supported by the guides. Recommended is 12 sessions of therapeutic exercises 97110, active therapeutic procedures (one on one) 97530 and manipulation 98941 at a frequency of 3 times a week for 4 weeks.

Citation/Evidence: 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 under exercises are recommended. There is strong evidence that exercise reduces disability duration in employees with low back pain. In acute back pain, exercise therapy may be effective, whereas in subacute back pain, exercises with a graded activity program, and in chronic back pain, intensive exercising, should be recommended. The ODG guides Low Back under flexability 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. 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)". 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 daily 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 interrater reliability was excellent. (Gross, 2002) FCE subtests 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).

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

ODG:

Lower back, procedure summary, exercises