

# P&S Network, Inc.

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## MEDICAL RECORD REVIEW:

**DATE OF REVIEW:** 07-25-07

**IRO CASE #:**

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

This case was reviewed by a Chiropractor. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

12 SESSIONS OF PHYSICAL THERAPY (97110) (97035)

## **REVIEW OUTCOME**

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

Partially Overturned (Agree in part/Disagree in part)

Certify three sessions of physical therapy consisting of the 97110 code only, and non-certify the 97035 code and the remainder of the nine requested physical therapy sessions.

## **REVIEW OF RECORDS**

- o Submitted medical records were reviewed in their entirety.
- o May 22, 2007 utilization review letter by D.C.
- o April 24, 2007 utilization review letter by D.C.
- o July 6, 2007 Texas Department of Insurance notice to utilization review agent of assignment of independent review organization
- o April 19, 2007 pre-authorization request from Rehab
- o April 13, 2007 subsequent evaluation report by D.C.
- o May 9, 2007 reconsideration for post-injection physical therapy letter by D.C.
- o June 2, 2007 consideration for post-injection physical therapy letter by D.C.

## **CLINICAL HISTORY SUMMARY**

According to the medical records, the patient sustained an industrial injury involving the low back. A subsequent evaluation report dated April 13, 2007 states that the patient reports constant low back pain that is graded at a 4/10. In addition, he complains of right leg pain. The pain is worse when he is walking or standing. The patient received three injections that were three weeks apart. Specifically, the patient had lumbar facet injections on January 2, 2007 and January 23, 2007. He saw another physician for a designated doctor evaluation on February 23, 2007. The physician opined that the patient is not at MMI. He sought yet another physician on February 27, 2007 who recommended facet rhizotomy and a lumbar discogram. The patient had a facet rhizotomy on April 11, 2007.

An April 13, 2007 report includes examination findings of +1 right patellar reflex, +1 right ankle reflex, decreased sensation at L5-S1, normal motor evaluation, positive straight leg raise on the right at 65° and left at 60° with an increase in low back pain, positive bilateral Kemp's test for severe low back pain, positive minor sign for severe low back pain, positive right Faber's test for pain in the hip and lumbosacral area, ambulation with a cane, severe myofascial trigger points, and myospasm in the paraspinal

muscles.

The report states that according to Rule 134.600 (h) (15) (B) (ii), surgical procedures that cause exacerbations require physical therapy. Twelve sessions of active and passive physical therapy were recommended. The report notes that massage will be implemented in order to promote relaxation of the musculature, provide relief from pain, and improve the range of motion. Interferential and ultrasound will be utilized to control the areas most afflicted with pain. A gentle joint mobilization will be applied to increase the range of motion of the joint, decreased pain, and to improve general circulation to the affected area. The patient will reportedly progress to therapeutic exercises under direct supervision intended to increase cardiovascular endurance, neuromuscular reeducation, proprioception, and increase range-of-motion. Treatment was requested consisting of 12 sessions of post-injection physical therapy to include therapeutic exercises (97110), interferential current (G 0283), joint mobilization (97140), myofascial release (97140), and ultrasound (97035).

An April 24, 2007 utilization review letter rendered a non-certification for the 12 physical therapy visits. This report notes that the patient has had nine sessions of physical therapy to date. In addition, it states that the patient was currently working light duty, four hours daily. The reviewer opined that the benefit from post-injection physical therapy probably does not extend past the initial visit, and there is no documentation in the literature with large, randomized populations with blinded evaluators, that extends past one week. The report notes that the claimant should do just as well with the self-directed home exercise program. In addition, the reviewer noted that ultrasound is not medically necessary based on evidence-based guidelines.

A May 9, 2007 reconsideration letter from the requesting doctor states that physical therapy has been advantageous to the patient's condition. The patient's range of motion and strength have reportedly increased and his pain levels have decreased since the date of injury. The patient had an exacerbation of pain due to the epidural steroid injection. Given that physical therapy has been proven beneficial in the past, the doctor opined that it is reasonable to assume that the same treatment would be effective for the patient post-exacerbation status. The doctor again cited the rule regarding surgical procedures that cause exacerbations and also cited the Official Disability Guidelines, page 160, which state that a total of up to 18 visits over 6-8 weeks with evidence of objective functional improvement is medically necessary.

A May 22, 2007 utilization review letter also rendered a decision of non-certification for the 12 visits. The reviewing doctor noted that, according to guidelines, the patient may experience an increase in pain for five to seven days after rhizotomy, with pain relief in two to three weeks. It was noted by the reviewer that the patient was examined by the requesting doctor just two days after the procedure. She stated that the procedure is commonly used to provide a window of pain relief allowing for participation in active therapy.

A June 2, 2007 reconsideration letter reiterates that the patient has had an exacerbation due to epidural steroid injections. The letter notes that passive physical therapy is necessary to reduce inflammation and associated pain due to the epidural steroid injection. Without passive care, the treatment will not be effective in the doctor's opinion.

#### **ANALYSIS AND EXPLANATION OF DECISION**

As noted above, the patient has undergone nine physical therapy visits for this injury. The Official Disability Guidelines (ODG) recommend 10 physical therapy visits for the patient's condition. In addition, these guidelines do not recommend ultrasound or interferential therapy. At this stage of the patient's condition, which is now over one year old, the emphasis should clearly be on active rehabilitation for functional restoration. The patient had exhausted conservative management and received a more invasive procedure of lumbar facet rhizotomy. At this stage, the patient has largely undergone the route of conservative care, which was not adequate. Given that he has undergone nine previous physical therapy visits, which is close to the maximum recommended by the ODG, he should be well-versed in an independent home exercise program. Given his exacerbation to the recent procedure, although this is often expected, it is reasonable to allow the patient an additional three sessions of physical therapy focusing on active rehabilitation and further instruction in an independent home exercise program.

The IRO's decision is consistent with the following guidelines:

#### **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

\_\_\_x\_\_\_ 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

Under study. Conflicting evidence does not allow for a recommendation. Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints. Three randomized controlled trials have been completed on this topic, but these studies all had potential clinical methodologic flaws including the use of non-controlled diagnostic blocks for all three, and potential discrepancies in technique of lesioning from that which is currently recommended. (Hooten, 2005) (Boswell, 2005) (Leclaire, 2001) (Gallagher, 1994) When compiled into systematic reviews, the evidence has been found to be conflicting for a short-term effect (Niemisto-Cochrane, 2003) (Niemisto-Cochrane, 2006) and moderate to strong for a long-term effect when compared to a placebo. (Geurts, 2001) (Boswell, 2005) The latter systematic review failed to distinguish results between lumbar and cervical patients. A critical nonsystematic review by Slipman et al. reported "sparse evidence" to support use in the lumbar region (Slipman, 2003) and the ICSI did not feel the current scientific evidence allowed for a conclusion on the subject. (ICSI, 2005) There has been one recent randomized controlled trial in the Netherlands that did not include confirmatory blocks. (van Wijk, 2005) No difference was found between radiofrequency nerve denervation and sham treatment, although the VAS score improved in both groups and the global perceived effect improved after radiofrequency. The authors suggested that radiofrequency neurotomy appeared to be more effective than sham treatment in a select group of patients with some of the variables including "psychological stability," female gender, age > 40 years, longer duration of pain, employed status, and no history of back surgery. Patients may experience an increase in pain for 5 to 7 days after the block, with pain relief in 2 to 3 weeks. Retrospective analysis has determined that the mean duration of relief is approximately 10-12 months (range 4-19 months). (Schofferman, 2004) Potential side effects include painful cutaneous dysesthesias, increased pain due to neuritis or neurogenic inflammation, and cutaneous hyperesthesia. (Boswell, 2005) The clinician must be aware of the risk of developing a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures. This procedure is commonly used to provide a window of pain relief allowing for participation in active therapy. (Washington, 2005) (Manchikanti, 2003) See also Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint medial branch blocks (therapeutic injections); Facet joint intra-articular injections (therapeutic blocks). Also see Neck Chapter and Pain Chapter.

Criteria for use of facet joint radiofrequency neurotomy:

1. Treatment requires a diagnosis of facet joint pain. See Facet joint diagnostic blocks (injections).
2. While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 70% relief.
3. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
4. No more than two joint levels are to be performed at one time.
5. If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.
6. There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.

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 self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Sprains and strains of back:

10 visits over 5 weeks

Lumbago:

9 visits over 8 weeks

Intervertebral disc disorders:

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (fusion): 34 visits over 16 weeks

Spinal stenosis:

10 visits over 8 weeks

Sciatica:

10-12 visits over 8 weeks

Fracture of vertebral column without mention of spinal cord injury

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

According to the Official Disability Guidelines (2007), ultrasound is not recommended. No proven efficacy in the treatment of acute low back symptoms. Therapeutic ultrasound is one of the most widely and frequently used electrophysical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. (van Tulder, 1997) (Philadelphia Panel, 2001) (Robertson, 2001)

According to the Official Disability Guidelines (2007), interferential therapy is not recommended. Interferential current stimulation is considered investigational. Interferential current works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz). See the Pain Chapter for more information and references. See also Sympathetic therapy.