



## IMED, INC.

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 12/22/08

**IRO CASE NO.:**

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

Item in dispute: Additional Physical Therapy Exercises Lumbar x 12 visits T1X x 4 weeks

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

Board Certified Orthopedic Surgeon

**REVIEW OUTCOME**

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

Denial Upheld

**PATIENT CLINICAL HISTORY (SUMMARY):**

The injured employee was a xx year old male who was helping someone lift a dock plate that weighed between 180 and 200 pounds. While lifting the dock plate, he felt a sharp pull in his low back, right leg, and buttock area.

The employee was initially referred to and saw Dr. M.D., on xx/xx/xx and was taken off work. The initial physical examination revealed muscle spasms with motion to the extremes but no focal neurologic deficits.

An MRI was performed on 09/30/08 that revealed multilevel lumbar spondylosis with severe left neural foraminal narrowing at L5-S1 and moderate spinal canal stenosis with moderate to severe bilateral neural foraminal narrowing at L4-L5. There was also noted to be a small right lateral disc herniation at L4-L5.

The employee was subsequently referred for physical therapy with a diagnosis of lumbar spondylosis without myelopathy, spinal stenosis of the lumbar region. It was also noted the employee had a previous spinal surgery and was off of work for at least ten months with his previous surgery. It was noted that the employee also initially complained of neck pain but his chief complaint at that time continued to be low back and right buttock pain. He denied symptoms past his right buttock.

The employee has undergone approximately twelve physical therapy visits based on the medical documentation and the request is for an additional twelve therapy visits.

The employee had an initial review by Dr. on 11/17/08 to determine the ongoing need for further physical therapy. Based upon the evidence of previous therapy being given and the fact that there was no evidence of acute radiculopathy, the additional therapy was denied. Upon examination, the employee was found to not have any significant radicular pain, and it was also noted that he should have been able to perform any additional therapy based on a home exercise program.

A follow-up review was performed by Dr. on 11/24/08. Again, the requested twelve therapy visits were not approved based on the fact that the employee had only mild soreness and weakness in the buttocks and mild left gluteal region. There was a negative straight leg raise bilaterally, strength was 5/5, and no evidence of significant radicular pain.

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

Based upon the clinical data contained in the submitted records, I would concur with the previous reviewer's determination. No further physical therapy is indicated under the **Official Disability Guidelines**. Current evidenced-based guidelines would have supported up to ten sessions of the physical therapy for exacerbation of low back pain. Records indicate that the employee sustained limited myofascial injuries that would improve with or without treatment. The employee's serial examinations do not establish that he has a recurrent radiculopathy requiring additional treatment.

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

1. The **Official Disability Guidelines**, 13th Edition, The Work Loss Data Institute. Recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. See also [Exercise](#). Direction from physical and occupational therapy providers can play a role in this, with the evidence supporting active therapy and not extensive use of passive modalities. The most effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle-strengthening exercises seem to be the most effective types of exercises for treating chronic low back pain. ([Hayden, 2005](#)) Studies also suggest benefit from early use of aggressive physical therapy ("sports medicine model"), training in exercises for home use, and a functional restoration program, including intensive physical training, occupational therapy, and psychological support. ([Zigenfus, 2000](#)) ([Linz, 2002](#)) ([Cherkin-NEJM, 1998](#)) ([Rainville, 2002](#)) Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. ([Mannion, 2001](#)) ([Jousset, 2004](#)) ([Rainville, 2004](#)) ([Airaksinen, 2006](#)) One clinical trial found both effective, but chiropractic was slightly more favorable for acute back pain and physical therapy for chronic cases. ([Skargren, 1998](#)) A spinal stabilization program is more effective than standard physical therapy sessions, in which no exercises are prescribed. With regard to manual therapy, this approach may be the most common physical therapy modality for chronic low back disorder, and it may be appropriate as a pain reducing modality, but it should not be used as an isolated modality because it does not concomitantly reduce disability, handicap, or improve

quality of life. ([Goldby-Spine, 2006](#)) Better symptom relief is achieved with directional preference exercise. ([Long, 2004](#)) As compared with no therapy, physical therapy (up to 20 sessions over 12 weeks) following disc herniation surgery was effective. Because of the limited benefits of physical therapy relative to "sham" therapy (massage), it is open to question whether this treatment acts primarily physiologically, but psychological factors may contribute substantially to the benefits observed. ([Erdogmus, 2007](#)) See also specific physical therapy modalities, as well as [Exercise](#); [Work conditioning](#); [Lumbar extension exercise equipment](#); [McKenzie method](#); & [Stretching](#). [Physical therapy is the treatment of a disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, activities of daily living and alleviating pain. ([BlueCross BlueShield, 2005](#)) As for visits with any medical provider, physical therapy treatment does not preclude an employee from being at work when not visiting the medical provider, although time off may be required for the visit.]

***Active Treatment versus Passive Modalities:*** The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with acute low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. ([Fritz, 2007](#)) The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530).

***Patient Selection Criteria:*** Multiple studies have shown that patients with a high level of fear-avoidance do much better in a supervised physical therapy exercise program, and patients with low fear-avoidance do better following a self-directed exercise program. When using the Fear-Avoidance Beliefs Questionnaire ([FABQ](#)), scores greater than 34 predicted success with PT supervised care. ([Fritz, 2001](#)) ([Fritz, 2002](#)) ([George, 2003](#)) ([Klaber, 2004](#)) ([Riipinen, 2005](#)) ([Hicks, 2005](#)) Without proper patient selection, routine physical therapy may be no more effective than one session of assessment and advice from a physical therapist. ([Frost, 2004](#)) Patients exhibiting the centralization phenomenon during lumbar range of motion testing should be treated with the specific exercises (flexion or extension) that promote centralization of symptoms. When findings from the patient's history or physical examination are associated with clinical instability, they should be treated with a trunk strengthening and stabilization exercise program. ([Fritz-Spine, 2003](#))

***Post Epidural Steroid Injections:*** ESIs are currently recommended as a possible option for short-term treatment of radicular pain (sciatica), defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The general goal of physical therapy during the acute/subacute phase of injury is to decrease guarding, maintain motion, and decrease pain and inflammation. Progression of rehabilitation to a more advanced program of stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based research that addresses the use of physical therapy post ESIs, but it appears that most randomized controlled trials have utilized an ongoing, home directed program post injection. Based on current literature, the only need for further physical therapy treatment post ESI would be to emphasize the home exercise program, and this requirement would generally be included in the currently suggested maximum visits for the underlying condition, or at least not require more than 2 additional visits to reinforce the home exercise program. ESIs have been found to have limited effectiveness for treatment of chronic pain. The claimant should continue to follow a home exercise program post injection. ([Luijsterburg, 2007](#)) ([Luijsterburg2, 2007](#)) ([Price, 2005](#)) ([Vad, 2002](#)) ([Smeal, 2004](#))

## **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](#), including assessment after a "six-visit clinical trial".

### **Lumbar sprains and strains (ICD9 847.2):**

10 visits over 8 weeks

### **Sprains and strains of unspecified parts of back (ICD9 847):**

10 visits over 5 weeks

### **Sprains and strains of sacroiliac region (ICD9 846):**

Medical treatment: 10 visits over 8 weeks

### **Lumbago; Backache, unspecified (ICD9 724.2; 724.5):**

9 visits over 8 weeks

### **Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):**

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

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

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

### **Intervertebral disc disorder with myelopathy (ICD9 722.7)**

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

### **Spinal stenosis (ICD9 724.0):**

10 visits over 8 weeks

See 722.1 for post-surgical visits

### **Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):**

10 – 12 visits over 6 weeks

See 722.1 for post-surgical visits

### **Fracture of vertebral column without spinal cord injury (ICD9 805):**

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

### **Fracture of vertebral column with spinal cord injury (ICD9 806):**

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

### **Work conditioning (See also [Procedure Summary](#) entry):**

10 visits over 8 weeks