

SENT VIA EMAIL OR FAX ON  
Dec/05/2008

## True Resolutions Inc.

An Independent Review Organization  
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**DATE OF REVIEW:**  
Dec/3/2008

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
18 sessions of PT 3 X 6 weeks

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Denial Letters 9/26/08 and 10/22/08  
Records from 8/4/08 thru 10/15/08  
PT Eval 9/13/08

**PATIENT CLINICAL HISTORY SUMMARY**

This man was seen by Dr. in. He is a new patient. Reportedly he was injured in xxxx and treated with a cervical fusion. He subsequently had a laminectomy form L2-3, L4-5, and a typo error for a third level. This was not for the work related injury. He has been on large doses of opiates, mainly Duragesic. Dr. feels this person would benefit from physical therapy in order to reduce his use of opiates, improve function and aerobic conditioning. The therapists note deconditioning and weakness. He has been in a counseling program as well. The therapists advised 18 sessions of therapy, Dr., after the denial, feels 6 sessions will work.

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

There are some unresolved issues here. Is the pain medication and the deconditioning for the work related cervical problem or the lumbar problem. It is impossible to limit the medication and therapy for one area or another.

The physical therapists requested 18 sessions, but Dr. revised that to 6 sessions.

The ODG section on chronic pain does recognize PT, but not for chronic neck and back pain. It can be justified of radiculitis, but the phrasing suggests that it be for something different.

#### Physical medicine treatment

Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of acute pain treatment or acute exacerbations of chronic pain and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with 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)

#### ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 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

Myalgia and myositis, unspecified (ICD9 729.1)

9-10 visits over 8 week

Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2)

8-10 visits over 4 week

Reflex sympathetic dystrophy (CRPS) (ICD9 337.2)

26 visits over 16 weeks

Another section of the ODG does recognize the role of active therapy for neck pain.

97110 Therapeutic exercises and treatment for strength and movement recover

Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

Medicare Fee Schedule: \$30

721.0 Cervical spondylosis without myelopathy WC Frequency: 80.38

721.1 Cervical spondylosis with myelopathy WC Frequency: 76.08

722 Intervertebral disc disorders WC Frequency: 79.04

722.0 Displacement of cervical intervertebral disc without myelopathy WC Frequency: 77.86

722.4 Degeneration of cervical intervertebral disc WC Frequency: 81.94

722.71 Cervical region WC Frequency: 72.72

722.91 Cervical region WC Frequency: 88.23

723.1 Cervicalgia WC Frequency: 24.05

723.3 Cervicobrachial syndrome (diffuse) WC Frequency: 52.00

723.4 Brachia neuritis or radiculitis NOS WC Frequency: 50.10%

The Texas Medical Board Rules Chapter 170 discusses opioid use and encourages alternative treatments to reduce their uses. The ODG does discuss weaning people from opioids, but did not address PT.

#### Weaning of medication

Recommended as indicated below. Opioids: For opioids a slow taper is recommended. The longer the patient has taken opioids, the more difficult they are to taper. The process is more complicated with medical comorbidity, older age, female gender, and the use of multiple agents. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. (Benzon, 2005) Patients with complex conditions with multiple comorbidities (including psych disorders) should be referred to an addiction medicine/psychiatry specialist. Opioid weaning should include the following: (a) Start with a complete evaluation of treatment, comorbidity, psychological condition; (b) Clear written instructions should be given to the patient and family; (c) If the patient can not tolerate the taper, refer to an expert (pain specialist, substance abuse specialist); (d) Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal); (e) A slower suggested taper is 10% every 2 to 4 weeks, slowing to a reductions of 5% once a dose of 1/3 of the initial dose is reached; (f) Greater success may occur when the patient is switched to longer-acting opioids and then tapered; (g) Office visits should occur on a weekly basis; (h) Assess for withdrawal using a scale such as the Subjective Opioid Withdrawal Scale (SOWS) and Objective Opioid Withdrawal Scale (OOWS); & (i) Recognize that this may take months.

As a result, it would appear that the ODG would justify 6 sessions of active therapy in the management of chronic pain with the intent to reduce pain medications.

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

- ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)