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

DATE OF REVIEW: 09/11/2008 AMENDED 09/17/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy X 12.

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 MD, specializing in Orthopedic Trauma, Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

REVIEW OUTCOME:

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

☒ Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Physical Therapy X 12.	97110, 97010	-	Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

This female suffered a lifting injury with strain/sprain of the cervical and lumbar regions xx/xx/xx. There was an Initial evaluation and treatment at a Medical Center. She has been treated for strain/sprain with physical

therapy. Apparently, the symptoms of cervical spine strain/sprain have resolved. She has persistent lumbar pain and right leg pain. Additional physical therapy of 3 x a week for 4 weeks was requested and denied on 2 occasions. The actual indications for request and expectations are not documented.

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

There is insufficient documentation available to justify additional physical therapy. In fact, it is not clear to which area of the spine the provider is requesting additional physical therapy. The extent to which physical therapy was prescribed at the Medical Center and the extent to which the patient was seen in physical therapy is not clear. This request for additional physical therapy should be denied as inadequately documented.

Physical therapy (PT)	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). *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. (Luijesterburg, 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. **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): 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 8 weeks See 722.1 for post-surgical visits **Curvature of spine** (ICD9 737) 12 visits over 10 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
Physical therapy (PT)	Recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider, to avoid debilitation and further restriction of motion. (Rosenfeld, 2000) (Bigos, 1999) For mechanical disorders for the neck, therapeutic exercises have demonstrated clinically significant benefits in terms of pain, functional restoration, and patient global assessment scales. (Philadelphia, 2001) (Colorado, 2001) (Kjellman, 1999) (Seferiadis, 2004) Physical therapy seems to be more effective than general practitioner care on cervical range of motion at short-term follow-up. (Scholten-Peeters, 2006) In a recent high quality study, mobilization appears to be one of the most effective non-invasive interventions for the treatment of both pain and cervical range of motion in the acutely injured WAD patient. (ConlinI, 2005) A recent high quality study found little difference among conservative whiplash therapies, with some advantage to an active mobilization program with physical therapy twice weekly for 3 weeks. (Kongsted, 2007) See also specific physical therapy modalities, as well as Exercise. 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. **Cervicalgia (neck pain); Cervical spondylosis** (ICD9 723.1; 721.0): 9 visits over 8 weeks **Sprains and strains of neck** (ICD9 847.0): 10 visits over 8 weeks **Displacement of cervical intervertebral disc** (ICD9 722.0): Medical treatment: 10 visits over 8 weeks Post-injection treatment: 1-2 visits over 1 week Post-surgical treatment (discetomy/laminectomy): 16 visits over 8 weeks Post-surgical treatment (fusion): 24 visits over 16 weeks **Degeneration of cervical intervertebral disc** (ICD9 722.4): 10-12 visits over 8 weeks See 722.0 for post-surgical visits **Brachia neuritis or radiculitis NOS** (ICD9 723.4): 12 visits over 10 weeks See 722.0 for post-surgical visits **Post Laminectomy Syndrome** (ICD9 722.8): 10 visits over 6 weeks

	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

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

ODG Physical Therapy Guidelines