



Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 7/28/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for

1. 12 visits beginning 5/29/09, 3 times a week for 4 weeks
2. Lumbar decompression (97012)
3. Attended e-stim (97032)
4. Neuromuscular re-education (97112)
5. Therapeutic activity (97530).

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

Texas licensed Chiropractor

REVIEW OUTCOME:

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

- Upheld (Agree)
- Overturned (Disagree)

X Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for

1. 12 visits beginning 5/29/09, 3 times a week for 4 weeks modified to **ten visits over four weeks**

Gender: xx
Date of Injury: xx/xx/xx
Mechanism of Injury: 1. Lifting a 200 gallon water tank, weighing 700-750 pounds.
2. Moving a 200-pound plate, pushing, lifting.
3. "Moving a storage tank."

Diagnosis: Post L5-S1 fusion, 12/28/05; lumbago; lumbar intervertebral disc displacement without myelopathy; lumbar strain; muscle spasms; bilateral lumbar radiculopathy; lumbar nerve root irritation; lumbar facet arthropathy; lumbar post laminectomy syndrome, L5-S1; degenerative disc disease; osteoarthritis of the knee (no side); migraine headache; hypertension; chronic pain; myofascial pain syndrome and prostatism.

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

This is a 5'9" tall 220 pound xx-year-old male who sustained a work related injury on xx/xx/xx, while working for, Inc. There were three mechanisms of injury stated in the documentation provided for review. The first was when he was lifting a 200 gallon water tank weighing approximately 700-750 pounds. A second mechanism (stated in the Designated Doctor (DD) exam) indicated that he was moving a 200-pound plate, pushing and lifting when he felt an immediate back pain and something pop out. A third mechanism was stated as "moving a storage tank." The claimant is five years post injury status. The provided diagnoses Post L5-S1 fusion, 12/28/05; lumbago; lumbar intervertebral disc displacement without myelopathy; lumbar strain; muscle spasms; bilateral lumbar radiculopathy; lumbar nerve root irritation; lumbar facet arthropathy; lumbar post laminectomy syndrome, L5-S1; degenerative disc disease; osteoarthritis of the knee (no side); migraine headache; hypertension; chronic pain; myofascial pain syndrome and prostatism. The claimant presented to the office of chiropractic provider, DC on 5/28/09. According to a previous peer review notification letter dated 6/4/09, a case discussion took place with Dr., in which she indicated that she was aware that the spinal decompression traction was not supported in the guidelines. Dr. was also notified that there was a contraindication to spinal decompression traction therapy for this claimant due to the previous history of lumbar fusion at L5-S1. There was no clinical examination information to support the medical necessity for decompression therapy 97012 (**NOTE: Wrong code for spinal decompression**) or the provided 97032-attended electrical stimulation, 97112-neuromusculoskeletal re-education and 97530-therapeutic activity. A second review notification dated 6/10/09 indicates that a conversation took place with Dr. in which she indicated that the claimant was awaiting a pain management treatment with medications. There was an operative report dated 12/28/05, indicating that the claimant received an L5-S1 anterior discectomy, fusion, anterior Lumbar Tapered (LT)-Cages with bone morphogenic protein (BMP) and

anterior pyramid plate and screws by surgeon, MD. There was a report of a medical evaluation which was not dated or signed, but indicated that the claimant had reached maximum medical improvement (MMI) status as of 5/14/08, with twenty five (25) percent impairment rating. There was a designated doctor report from MD dated 5/15/08. His report indicated findings on X-ray of the lumbar spine on 9/14/06 indicated a probable solid fusion. A CT scan of the lumbar spine on 9/27/06 identified no evidence of residual mobility at the L5-S1 level. Medications at that time were Lotrel, Methadone, Soma and Lidoderm patch. Dr. report also indicated that the sensory exam was normal. The reflexes were decreased with right Achilles reflex grade 0 and left 1 with the remainder graded 2. The motor weakness was noted in the bilateral ankle plantar flexion at +4 with the remainder +5. The claimant presented to, MD, on 8/14/08, with continued complaints rated 9/10 in the low back. On 9/20/08, he presented for chiropractic treatment at Chiropractic Concepts with, DC, with 8/10 constant low back pain across the back. **There was no measurable evidence within the provided documentation which supports treatment efficacy with chiropractic treatments.** On 1/15/09, the claimant presented to Dr. for consideration of pain management options for his constant 5/10 low back and bilateral leg pain. The 4/7/09 date of service with Dr., indicated exam findings of normal mood and affect, normal gait, strength at 5/5, normal deep tendon reflexes (DTR's) +2 throughout and a normal sensory exam. The claimant moved from back to and changed treating doctors to Dr. , on 5/28/09. He was taking Norco, Soma and Lidoderm patch for his persistent low back pain and had discontinued the Methadone due to an adverse reaction. He was referred to pain management to co- manage his care and medications. The appeal letter from Dr. on 6/13/09, indicated that the treatment provided was medically necessary. On exam, there was grade 5/5 motor strength noted and normal reflexes. There was right-sided antalgic gait with positive Minor's sign. There was also positive Goldthwaite's sign bilaterally, bilateral Kemp's test and Bechterew's test bilaterally. The ranges of motion were significantly decreased with flexion 43 degrees, extension 8 degrees, and bilateral lateral flexion 18 degrees. He was noted as being trained as a plumber, but was going to college to obtain a degree in English. To date, the provided records indicate active and passive physical therapy, lumbar injections, lumbar fusion surgery, post surgical rehabilitation, post surgical pain management, passive and active chiropractic treatments, medications, multi disciplinary doctor management, retraining in another field of work and lumbar spinal decompression traction therapy concurrently with active and passive modalities from Dr. since at least 5/28/09. There has not been a new injury or re-injury noted. There was no evidence of re-surgical intervention. There was no evidence that the claimant had returned to any form of employment at this time. There was no recent or number of physical medicine treatments identified within the documentation for 2009. The current request is to determine the medical necessity for twelve visits beginning on 5/28/09 at 3 times a week for 4 weeks, with CPT codes of 97012-lumbar decompression treatment (wrong CPT code), 97032-attended electrical stimulation, 97112-neuromusculoskeletal reeducation and 97530-therapeutic activity. The medical necessity for this request is established for a modification to include CPT codes of neuromuscular reeducation for the gait disturbance and decreased ranges of motion, as well as the therapeutic activities (exercises) for the chronic pain and lumbar range of

motion deficits and positive orthopedic testing for 10 visits over 4 weeks to address any remaining deficits which can reasonably be improved, transfer the care, re-educate on home exercises and home care with the new provider and re-check the claimant for compliance and ability to perform the home care program for his chronic pain and failed back surgical condition. The references do not support the passive vertebral axial decompression (VAX-D) traction or any form of traction. Additionally, there was a contraindication for vertebral axial decompression due to the fusion of the lumbar spine. The references do not support attended or unattended electrical stimulation/interferential therapy treatments. The reference to support this modified determination was found in the ODG, regarding post surgical lumbar fusion surgery and chronic pain with treatment modalities of lumbar decompression therapy, electrical stimulation, neuromusculoskeletal reeducation and therapeutic activity. The first reference is directed to <http://www.odg-twc.com/bp/722.htm#722.8> for failed back surgery or post laminectomy syndrome which supports, "10 visits over 8 weeks." The sub reference to physical therapy at http://www.odg-twc.com/odgtwc/low_back.htm#Physicaltherapy indicates that it is *"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. 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"* and that, *"Active Treatment versus Passive Modalities: The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes."* For the diagnosis of chronic pain syndrome, the guidelines at <http://www.odg-twc.com/bp/338.htm#338.2> were utilized. Sub reference to <http://www.odg-twc.com/odgtwc/pain.htm#Physicalmedicinetreatment> indicates physical therapy for neuralgia symptoms for up to "8-10 visits over 4 weeks" allowing for *"fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT."* Given the claimant's current documentation and the request for four weeks of expected treatments by Dr., then it would be reasonable to expect 10 visits over 4 weeks for his chronic pain complaints. The reference also indicates that *"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"* and that *"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.” Redirection to http://www.odg-twc.com/odgtwc/low_back.htm#Exercise indicates that “After back surgery, there is strong evidence for intensive exercise programs for functional status and faster return to work and there is no evidence they increase the re-operation rate”. Re-direction to http://www.odg-twc.com/odgtwc/low_back.htm#Electricalstimulators redirects to http://www.odg-twc.com/odgtwc/low_back.htm#Interferentialtherapy which indicates that it is “Not generally recommended. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues.” Reference regarding vertebral axial decompression traction or any form of traction is found at http://www.odg-twc.com/odgtwc/low_back.htm#Poweredtractiondevices which indicates that it is “Not recommended. While there are some limited promising studies, the evidence in support of powered traction devices in general, and specifically vertebral axial decompression, is insufficient to support its use in low back injuries. Vertebral axial decompression for treatment of low back injuries is not recommended. VAX-D therapy may also have risks, including the potential to cause sudden deterioration requiring urgent surgical intervention” and that, “The evidence suggests that any form of traction is probably not effective. Neither continuous nor intermittent traction by itself was more effective in improving pain, disability or work absence than placebo, sham or other treatments for patients with a mixed duration of LBP, with or without sciatica. Additionally indicated is that “The efficacy of spinal decompression achieved with motorized traction for chronic discogenic low back pain remains unproved” and lastly, “that adding IDD Therapy to a standard graded activity program has been shown not to be effective.” The reference to support the neuromuscular re-education is not found in the ODG, and is referenced in the 2009, 17th Annual ChiroCode DeskBook, Section D, page 97 under CPT code 97112. This reference indicates that this procedure is performed for re-education of movement, balance, coordination, kinesthetic sense, posture, and or proprioception for sitting and standing activities one or more areas each 15 minutes. The claimant does meet those criteria within the notes. Therefore, due to the decreased ranges of motion and abnormal gait with antalgic posture (Minor’s sign), it would be reasonable to include this service. **The decision is to support a modification to include the guideline recommendation for chronic pain of ten visits over four weeks with CPT codes of 97112-neuromusculoskeletal reeducation and 97530-therapeutic activity.** There was no indication of outlier status to justify more than the recommended 10 visits over 4 weeks given the available information. There was also no evidence of an efficacious outcome assessment from this provider regarding these visits. Additionally, the determination includes upholding the denial for 12 visits over 4 weeks of 97012-lumbar decompression treatment (wrong CPT code) and 97032-attended electrical stimulation.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
ODG, Treatment index, 7th Edition, web based version regarding post surgical lumbar fusion surgery with treatment modalities of lumbar decompression therapy, electrical stimulation, neuromusculoskeletal reeducation and therapeutic activity.
<http://www.odg-twc.com/bp/722.htm#722.8>
http://www.odg-twc.com/odgtwc/low_back.htm#Physicaltherapy
http://www.odg-twc.com/odgtwc/low_back.htm#Exercise
http://www.odg-twc.com/odgtwc/low_back.htm#Electricalstimulators
http://www.odg-twc.com/odgtwc/low_back.htm#Interferentialtherapy
http://www.odg-twc.com/odgtwc/low_back.htm#Poweredtractiondevices
<http://www.odg-twc.com/bp/338.htm#338.2>
<http://www.odg-twc.com/odgtwc/pain.htm#Physicalmedicinetreatment>
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION).

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).
17th Annual ChiroCode DeskBook, Section D, page 97 under CPT code 97112