

SENT VIA EMAIL OR FAX ON  
Jun/03/2009

## **IRO Express Inc.**

An Independent Review Organization

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**DATE OF REVIEW:**

May/27/2009

**IRO CASE #:**

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

Physical Therapy

**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

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC SURGERY

**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-4/10/09 and 4/30/09

-10/08-4/09

Radiology Assoc.-10/14/08; 10/20/08

**PATIENT CLINICAL HISTORY SUMMARY**

This is a woman reported with neck and low back pain since an injury in xxxx. She is not taking pain medications. Dr. described improved neck pain after some injection last fall, presumably an ESI, but I could not exclude a trigger point examination. Her neck pain improved. She has low back pain going to both lower extremities. Dr. diagnosed cervical and lumbar radiculopathy, but the neurological exam was described in the multiple reports reviewed as "nonfocal." He wrote she has low back pain going to both legs. The cervical exam showed increased lordosis, the lumbar exam showed reduced lordosis. Both showed local tenderness and reduced motion. The most recent lumbar xray in 2008 showed I5/S1 disc space narrowing. The cervical MRI showed left paracentral disc herniation at C6/7 and multiple level foraminal stenosis.

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

Although, there may be a radicular pain pattern, there was no described neurological loss to document a radiculopathy. The injury is years ago. The ODG recommends therapy with the emphasis on home/self directed programs. There is a role for therapy after epidural injections, but the Reviewer's impression is that the therapy is for the lumbar more than the cervical region, and the cervical injections were more than 6 months ago. Based on this information and the material provided, the Reviewer cannot disagree with the prior adverse determination.

Physical therapy (PT) Cervical

**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. (Conlin, 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, including assessment after a "six-visit clinical trial"

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 week

Displacement of cervical intervertebral disc (ICD9 722.0)

Medical treatment: 10 visits over 8 week

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

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

Post-surgical treatment (fusion, after graft maturity): 24 visits over 16 week

Degeneration of cervical intervertebral disc (ICD9 722.4)

10-12 visits over 8 week

See 722.0 for post-surgical visit

Brachia neuritis or radiculitis NOS (ICD9 723.4)

12 visits over 10 week

See 722.0 for post-surgical visit

Post Laminectomy Syndrome (ICD9 722.8)

10 visits over 6 week

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

Medical treatment: 8 visits over 10 week

Post-surgical treatment: 34 visits over 16 week

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

Medical treatment: 8 visits over 10 week

Post-surgical treatment: 48 visits over 18 week

Work conditioning (See also Procedure Summary entry)

10 visits over 8 weeks

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.

**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)