

Prime 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-9015
Email: manager@prime400.com

DATE OF REVIEW:

May/04/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

9 units each of Ultrasound Therapy (97035), Therapeutic Exercises (97110), Manual Therapy (97140) and Group Therapeutic Procedures (97150)

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

MD, Board Certified in Physical Medicine and Rehabilitation
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

PATIENT CLINICAL HISTORY SUMMARY

This man developed back pain on xx-xx-xx. He was initially diagnosed with a lumbar strain and later with a radiculopathy and disc herniation. His MRI on 11/23/08 described disc bulges moderate at L4/5 and mild at L5/S1. There was bilateral foraminal narrowing and the bulges entered the foramen. The MRI did not describe nerve root compression. He had an EMG on 2/11/09 that was reported as normal. His complaints were pain and sensory problems initially in the right lower extremity and subsequently in both lower extremities. He was treated with 22 sessions of physical therapy that included spinal stabilization and passive modalities. The therapists were encouraged by his improvement, but he felt unimproved. He commented that he wanted to be fixed. The last note provided was from Dr. on 3/6/09 that described severe and increased pain with the addition of left leg numbness and tingling. Dr. commented several times about his being neurologically intact except for hyperreflexia. The

therapists made numerous comments of his progress, but also of his perception that he was not progressing.

12/29 This man “reports continued intermittent episodes of low back pain. He denies symptoms currently. He also states he is not working on his HEP because he is sure that these exercises are not going to help him. HEP participation was encouraged. “

1/12 “He is not progressing overall, based on his subjective reports of continued low back pain outside the clinic.”

1/13 “He felt basically the same.” However the therapist wrote that “The patient is making appropriate progress for condition.”

1/14 “Patient states “the therapy is helping”...We have tried to progress his program at the last few PT sessions, but he feels he is doing “enough” and he does not want to do additional exercises.”

1/20 “He has been instructed to focus on his HEP and to be more optimistic that he will recover. He does not have symptom reports or difficulties with his stabilization program here in the clinic.” “He wants surgery. He wants to be fixed.”

1/21 In the last therapy note, it states: “He can complete his lumbar stabilization program without difficulty.”

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

This patient has had a back problem with preexisting issues including the foraminal narrowing. The records indicate the patient’s attitude was one that he was not interested in a home exercise program. He would participate, but did not see the progress his therapists reported. As noted, he stated he was going to see the surgeon to be “fixed,” even though the therapist did not feel he would need surgery. When the therapies stopped, his pain worsened. The records were not clear if he was performing the home exercise program, but it appears that he felt they caused more pain. This request is for additional passive treatment (ultrasound and manual therapy) plus the active exercise program. The ODG recognizes the role of PT in the management of back pain. It also describes the transfer of treatment from a passive program to a more active self directed one. Supervised therapy is more appropriate with fear avoidance, a factor not described by the therapists in this particular case. The therapy sessions are generally 8-10 at once weekly intervals. The records reviewed included reports for 16 sessions, although one of the peer reviewers stated the patient has had 23 sessions. This exceeds the numbers advised by the ODG, without the additional sessions requested. The request does not meet the guidelines. The reviewer finds that medical necessity does not exist for 9 units each of Ultrasound Therapy (97035), Therapeutic Exercises (97110), Manual Therapy (97140) and Group Therapeutic Procedures (97150).

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. (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. (, 2000) (2002) (1998) (2002) Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. (2001) (2004) (2004) (2006) One clinical trial found both effective, but chiropractic was slightly more favorable for acute back pain and physical therapy for chronic cases. (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. (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. (2007) See also specific physical therapy modalities, as well as Exercise; Work conditioning; Lumbar extension exercise equipment; 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. (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 Questionnaire (FABQ), scores greater than 34 predicted success with PT supervised care. (2001) (2002) (2003) (2004) (2005) (2005) Without proper patient selection, routine physical therapy may be no more effective than one session of assessment and advice from a physical therapist. (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. (2003)...

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 week

Sprains and strains of unspecified parts of back (ICD9 847)

10 visits over 5 week

Sprains and strains of sacroiliac region (ICD9 846)

Medical treatment: 10 visits over 8 week

Lumbago; Backache, unspecified (ICD9 724.2; 724.5)

9 visits over 8 week

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

Medical treatment: 10 visits over 8 weeks...

Intervertebral disc disorder with myelopathy (ICD9 722.7)

Medical treatment: 10 visits over 8 weeks...

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)