

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 11/19/2009

**IRO CASE #:** 23488

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

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

Continued physical therapy 3x/week x 4 weeks

**REVIEW OUTCOME**

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

Upheld (Agree)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 04-06-09 Medical report from Dr.
- o 04-13-09 Medical report from Dr.
- o 04-29-09 Lumbar MRI read by Dr.
- o 05-01-09 Medical report from Dr.
- o 05-15-09 Medical report from Dr.
- o 07-02-09 Medical report from Dr.
- o 07-13-09 Medical report from Dr.
- o 09-25-09 Medical report from Dr.
- o 09-28-09 Fax request for PT x 12 including PT Charge Sheets 19 pages
- o 10-01-09 Medical report from Dr.
- o 10-02-09 Initial Adverse Determination Letter
- o 10-21-09 Adverse Determination Letter on reconsideration
- o 10-27-09 Request for IRO from the provider
- o 10-29-09 Confirmation of Receipt of IRO from TDI
- o 11-02-09 Notice of Case Assignment from TDI

**PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records and prior reviews the patient is a male who sustained an industrial injury to the low back on xx/xx/xx when placing magazines on a lower rack. He initially reported lower extremity pain, however by an examination on April 6, 2009 he reported back pain only. The patient smokes a half pack of cigarettes per day.

X-rays taken on April 6, 2009 revealed an unremarkable examination. Clinically, lumbar ROM was restricted. He was prescribed Sterapred DS Dose Pack and Lortab. At recheck on April 13, 2009 the patient reported pain radiating into the bilateral legs. MRI

was approved.

Lumbar MRI was performed on April 29, 2009 and revealed a small central disc herniation at L4-5. The other discs are normal and no spinal stenosis is seen.

On May 1, 2009 the patient has a diagnosis of thoracic and lumbosacral pain with radiculitis. He is using Naprosyn, Robaxin and Norco. He was referred for epidural injection.

The patient was seen in Follow up on May 15, 2009. He wants to return to full duty. He wants to know if he needs clearance from pain management. He has good and bad days. Lumbar range of motion remains restricted. He is using Norco, Robaxin and Voltaren.

The medical report of July 2, 2009 notes the patient did not get significant relief with 2 epidural injections. He needs to return to pain management or initiate physical therapy. Straight leg raise is negative bilaterally. He is tender to palpation and motion is restricted. A referral was made for PT. On July 13, 2009 the provider reported the patient had a third epidural injection, which resulted in a spinal leak and headaches for three days. He wants to begin PT.

At reevaluation on September 25, 2009 the patient is using Lortab and Robaxin. Muscle strength and sensation are normal. Gait and stance are normal. He is using Norco. He is recommended to continue PT 3 times weekly for a month.

An additional 12 sessions of PT was requested on September 28, 2009 by the PT clinic. Attached were PT Charge Sheets covering visits between 08-20-09 and 09-23-09 (12 visits): At assessment, hip flexion and abduction was 4+/5. Sensation was decreased in the left L4 distribution. Straight leg raise elicited pain at 72 degrees on the left and 73 degrees on the right. Therapy content will include active and passive treatment and aquatic exercises. The charge sheets occasionally included handwritten notations: On August 27, 2009 a note states patient is "sick" and did not attend PT. Some of the notes are illegible. On August 31, 2009 body mechanics and lifting techniques were discussed. On September 2, 2009 the patient has pain with extension. His pain is decreased to 1-2/10. He reports a slipping feeling with standing and pain of 2/10 (09-04-09). He reports pain of 3/10. He reports no more slipping feeling (09-09-09). No treatment was provided on September 11, 2009 per the notes. Patient reports pain of 3-4/10 (9-14-09). On September 16, 2009 he states the weather makes him hurt more. He reports increased pain of 4/10 of unknown origin. Knee extension strength is 5/5; knee flexion strength is 4+/5 (09-18-09). He has good days and bad days. Trunk and upper abdominal strength is 4/5 (09-23-09).

On October 1, 2009 the patient reported PT was not authorized. He is using Lortab 7.5/500 mg 1-2 every 4-6 hours. Lumbar flexion and extension are decreased. There is tenderness in the lumbar midline. PT is the only thing that has been helpful according to the patient and an additional month would be beneficial. The therapist informed a letter is expected in several days clarifying why additional PT is not authorized.

Request for additional PT of 12 visits was considered in review on October 2, 2009 with recommendation made for non-certification. The Daily Progress notes were reviewed and do not include a reevaluation. Additionally, there are no MD notes available for review. ODG recommends a trial of 6 visits and overall, 10 sessions for the patient's diagnosis. No barriers to HEP were reported. A peer discussion was attempted but not realized. It was noted that, per the carrier, the only compensable injury is a lumbar disc herniation.

Request for reconsideration of 12 additional sessions of PT was considered in review on October 21, 2009 with recommendation for non-certification. A peer discussion was realized with a physician assistant who reported that the patient improved with 12 sessions so an additional 12 were requested. However, there has not been any objective functional changes, change in work status, or change in medication use. It was reported the patient missed his most recent follow-up of October 15, 2009. However, there remains inadequate reason to exceed ODG guidelines.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The patient is currently more than xxxx months post injury to the low back associated with lifting and bending activities. X-rays were unremarkable. MRI has revealed a small central disc herniation at L4-5 without indication of neurocompromise. Although no radiculopathy has been documented, the patient was provided 3 epidural injections which did not help and caused a spinal leak with headache. He continues with chronic low back pain which he describes as low grade and intensity of 1-3/10 with good days and bad days. The patient is a smoker and does not appear to be participating in a HEP. He wanted to return to full duty in May 2009. His work status is not currently clarified. 12 sessions of PT were provided with poor documentation and no reassessment provided indicating quantitative subjective and objective response to the treatment. The brief charge sheet notes do not indicate progressive improvement with the treatment. His pain level is higher at visit 11 than prior. The notes do not clarify instruction in HEP, although this is a standard PT protocol and it is anticipated the patient has been instructed in independent home exercises.

ODG recommends to 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. Lacking complete progress notes and a reassessment, the clinical findings do not establish a medical necessity for additional formal PT beyond the amount supported by ODG. Therefore, recommendation is to agree with the prior non-certification of the request for continued physical therapy 3x/week x 4 weeks.

The IRO's decision is consistent with the following guidelines:

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

- ACOEM- AMERICAN 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

The Official Disability Guidelines - Low Back Chapter (10-30-2009) Physical Therapy:

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. 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. Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. One clinical trial found both effective, but chiropractic was slightly more favorable for acute back pain and physical therapy for chronic cases. 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. Better symptom relief is achieved with directional preference exercise. 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.

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. 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). A recent RCT comparing active spinal stabilization exercises (using the GDS or Godelive Denys-Struyf method) with passive electrotherapy using TENS plus microwave treatment (considered conventional physical therapy in Spanish primary care), concluded that treatment of nonspecific LBP using the GDS method provides greater improvements in the midterm (6 months) in terms of pain, functional ability, and quality of life.

**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.

**Post-surgical (discectomy) rehab:** A recent Cochrane review concluded that exercise programs starting 4-6 weeks post-surgery seem to lead to a faster decrease in pain and disability than no treatment; high intensity exercise programs seem to lead to a faster decrease in pain and disability than low intensity programs; home exercises are as good as supervised exercises; and active programs do not increase the re-operation rate. Although it is not harmful to return to activity after lumbar disc surgery, it is still unclear what exact components should be included in rehabilitation programs. High intensity programs seem to be more effective but they could also be more expensive. Another question is whether all patients should be treated post-surgery or is a minimal intervention with the message return to an active lifestyle sufficient, with only patients that still have symptoms 4 to 6 weeks post-surgery requiring rehabilitation programs.

#### 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 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