



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 9-29-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 supervised rehabilitation sessions to include:
97110 Addtl Physical Therapy Lumbar Spine 3 x wk x 4 weeks
97124 Massage Therapy Lumbar Spine 3 x wk x 4 weeks
97140 Manual Therapy Lumbar Spine 3 x wk x 4 weeks
97530 Therapeutic Activities Lumbar Spine 3 x wk x 4 weeks
97113 Aquatic Therapy Lumbar Spine 3 x wk x 4 weeks
97035 Ultrasound Therapy Lumbar spine 3 x wk x 4 weeks
G0283 Electrical Stimulation Lumbar Spine 3 x wk x 4 weeks
97116 Gait Training Therapy Lumbar Spine 3 x wk x 4 weeks
97010 Hot/Cold Pack Therapy Lumbar Spine 3 x wk x 4 weeks

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

American Board of Orthopaedic Surgery-Board Certified

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)

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records reflect the claimant sustained a work related injury on xx/xx/xx while employed . On this date, the claimant reported she slipped and fell.

5-12-08 MD., Claimant complains of back pain. Claimant slipped and fell on a wet floor at work. She has some pain to her back and her right hip. She is able to walk but it hurts. There is no loss of consciousness, no head injury, and no neck pain. All other systems are negative. Assessment: Low back sprain and contusion secondary to fall, lumbosacral strain. Plan: Claimant was placed on Soma, Motrin, rest, to follow up with her doctor 2-3 days, return for new symptoms.

5-12-08 X-ray of pelvis performed by MD., showed mild degenerative changes to the sacroiliac joints. Bilateral facet arthropathy to the level of L5 and S1. Multiple pelvic calcifications.

5-12-08 X-ray of the lumbar spine showed extensive lumbar spine degenerative changes. Posterior spondylolisthesis at the level of L2 relative to L3. Anterior spondylolisthesis of L4 relative to L5 and L5 relative to S1. Atherosclerotic changes to the aorta. Bilateral facet arthropathy to the level of L5 and S1.

5-16-08 DC., DWC-73: Claimant was taken off work from 5-16-08.
Chiropractic Therapy from 5-16-08 through 8-20-09 (54 visits)

5-30-08 DC., DWC-73: Claimant was taken off work from 5-30-08.

6-3-08 Statement Accepted Facts: carrier's position that the claimant's injury to her low back is limited to the strain sprain injury as originally reported and treated. Carrier further denies that the claimant's injury to her low back extends to or affects the claimant's body in general or any other part of her body other than her low back. Carrier disputes any and all disability as related.

6-9-08 DC., Evaluator noted that he currently treating the claimant for injuries that she sustained on xx/xx/xx while working . Claimant has been off of work since the date of her accident. She has injuries to her lumbar spine and right leg. The injuries have weakened the ligament structure and are causing nerve root compression. She has a history of degenerative disc disease and arthritis to the lower back which complicates her injury and will cause her to have a longer recovery time than that of a healthy female. Of note, the claimant was asymptomatic at the time of her injury. Claimant has limited ability to sit, stand and walk due to her diagnosis.

6-13-08 DC., DWC-73: Claimant was returned to work from 6-16-08 through 7-7-08 with restrictions.

7-18-08 Functional Capacity Evaluation shows the claimant is functioning at a Light Capacity.

8-4-08 DC., DWC-73: Claimant was returned to work from 8-4-08 through 8-25-08 with restrictions.

8-25-08 DC., DWC-73: Claimant was returned to work from 8-25-08 through 9-5-08 with restrictions.

9-5-08 Functional Capacity Evaluation shows the claimant is functioning at a Light Capacity.

9-10-08 DC., DWC-73: Claimant was taken off work from 9-11-08.

9-18-08 MRI of the lumbar spine without contrast performed by MD., showed multilevel lumbar spondylosis, greatest at L4-L5 where there is a severe spinal canal stenosis and moderate bilateral foraminal narrowing. There is moderate spinal canal stenosis and moderate bilateral foraminal narrowing at L5-S1. There is a broad central disk herniation (extrusion type) and mild spinal canal stenosis at L2-L3, as well as at L3-L4. There is severe bilateral foraminal narrowing at L3-L4 and moderate bilateral foramina' narrowing at L2-L3. Grade-I anterolisthesis of L4 on L5 and anterolisthesis of L5 on S1, on the basis of bilateral facet osteoarthritis at each of these levels. Mild retrolisthesis of L2 on L3.

9-22-08 DC., DWC-73: Claimant was taken off work from 9-22-08.

9-25-08 MD., Claimant was sent over by Dr. for purpose of consultation regarding injury she sustained to the back while at work on xx/xx/xx. She states that she was leaning over to pick up some empty bottles when she slipped and fell hurting her back. She states that she has had pain off and on since that time. She has undergone therapy. She has received an MRI. However, she still has pain with walking, prolonged sitting, and at night when she is sleeping. She experiences burning to the right leg as well as some numbness. She denies previous problems to the back prior to this injury. Examination today demonstrates healthy appearing female in no distress. Lumbar spine demonstrates tenderness to the paravertebral musculature. There is no spasm. Forward flexion is restricted. She only touches her mid-tibias with the fingers. Lateral bending is 20 degrees bilaterally. Straight leg raise examination is negative. Motor strength is 5/5

to all major motor groups of the lower extremities. Sensory examination is intact to sharp/dull to the dorsal, lateral, and medial aspect of both feet. X-rays of the lumbar spine demonstrates grade I spondylolisthesis at L4-L5. There is calcification of the aorta. There is also grade I spondylolisthesis at L5-S1. There are degenerative changes at the facet joints at L5-S1. Diagnosis: Multilevel disc herniation. Lumbar sprain. Spondylolisthesis at L4-L5 and L5-S1. Plan: At this time, evaluator feels that her degenerative changes including spondylolisthesis and the spinal stenosis are all preexisting and degenerative in nature. Evaluator feels mostly that she has sustained a lumbar sprain as a result of her fall. Evaluator does recommend a course of therapy with Dr. to help reduce her pain. Evaluator will medicate her with Mobic 15 mg once a day and Soma 350 mg once in the evening and Ultram for breakthrough pain. Warnings regarding side effects and dosing schedule have been discussed. Evaluator will follow her back at my office in three weeks. DWC-73: Claimant was taken off work from 9-25-08.

9-30-08 DC., DWC-73: Claimant was taken off work from 9-30-08.

10-6-08 DC., DWC-73: Claimant was taken off work from 10-6-08.

10-16-08 MD., Claimant still having pain in my back with radiation down my right leg. Examination of lumbar spine demonstrates tenderness to the right sciatic notch. Forward flexion is restricted. She does have pain with walking. Diagnosis: Multilevel disc herniation. Lumbar sprain with preexisting spondylolisthesis at L4-L5 and L5-S1. Plan: At this time, evaluator will medicate her with Flector patch and Soma 350 mg once a day. Warnings regarding side effects and dosing scheduled have been discussed. Evaluator will refer her to Dr. for EMG nerve study of the right lower extremity to rule out radiculopathy. Evaluator will refer also to Dr. for consultative purposes for possible epidural block. Evaluator will follow her back at my office in four weeks.

10-17-08 DC., DWC-73: Claimant was taken off work from 10-17-08.

10-28-08 EMG/NCV performed by MD., was normal.

11-4-08 DC., DWC-73: Claimant was taken off work from 11-4-08.

11-13-08 MD., Claimant being followed for lumbar herniated disc, multilevel with lumbar sprain and preexisting spondylolisthesis at L4-L5 and L5-S1. Work injury was when she fell on xx/xx/xx. She states that she is doing better. She did not see Dr. as of yet. She states that she feels she can probably return back to work soon. Examination of lumbar spine demonstrates tenderness to the paravertebral musculature. Forward flexion allows her fingers to touch her ankles. Lateral bending is 30 degrees bilaterally. Straight leg examination is negative. Diagnosis: Multilevel disc herniation. Lumbar sprain with preexisting spondylolisthesis at L4-L5 and L5-S1. Plan: At this time, evaluator will medicate with Soma 350 mg once a day with appropriate warnings regarding side effects. Evaluator will try to obtain the results from Dr. 's office for the EMG study. Evaluator will hold off on the epidural injection. Evaluator will follow her back at my office in four weeks.

12-1-08 MD., Performed a Peer Review. It was the evaluator's opinion that the claimant sustained, at most, a self-limiting soft tissue injury to the lumbar spine, which was superimposed upon significant pre-existing degenerative disc disease. Evaluator found no evidence to suggest a structural injury to the lumbar spine related to the injury event at issue. The MRI findings from September 18, 2008 are unrelated to the occupational event of xx/xx/xx, pre-existing that injury. Evaluator sees no indication of aggravation or acceleration. Her current symptoms are related to her pre-existing degenerative disc disease. Evaluator see no indications for treatment outside of the ODG Guidelines, although evaluator would anticipate, with her degree of degenerative disc changes, her treatment may be somewhat protracted. Epidural steroid injections are occasionally used for temporal relief of symptom exacerbation in degenerative disc disease. Epidural steroid injections are not used for soft tissue injuries to the lumbar spine.

12-1-08 DC., DWC-73: Claimant was taken off work from 12-1-08.

12-18-08 MD., Claimant still having pain in my back. Claimant being followed for lumbar herniated disc multilevel with preexisting spondylolisthesis L4-L5 and L5-S1. Work injury was from a fall on xx/xx/xx. She has scheduled this upcoming Monday an epidural injection with Dr. She still has burning down the leg despite the previous EMG nerve study from Dr. which indicated a normal study of the right lower extremity. Examination of lumbar spine demonstrates tenderness to the paravertebral musculature, discomfort, and restriction with forward flexion and restriction with lateral bending. Straight leg examination is negative. Diagnosis: Multilevel disc herniation. Lumbar sprain with preexisting spondylolisthesis at L4-L5 and L5-S1. Plan: At this time, evaluator will await the lumbar epidural block. Evaluator will medicate her with Flector patch twice a day and Lyrica 75 mg twice a day. Warnings regarding side effects and dosing schedule have been discussed.

12-22-08 MD., The claimant's chief complaint is lower back pain, left lower extremity numbness, chronic intractable pain syndrome. Claimant suffered a fall where her legs ended up being split apart and hit her back and buttocks. Since then she has had pain to the lower back radiating to the left side and left lower extremity with numbness, which is present. On the (VAS) Visual Analog Scale, the claimant states pain at its worst is usually 7 out of 10 but at least 5 out of 10 since the injury in xx/xxxx. She has undergone therapy and chiropractic treatment. The claimant has noticed several changes with her activities of daily living. She has been using Lyrica and Lidoderm patches. Impression: lumbar disc herniation. Lumbar spondylosis. Lumbar spinal canal stenosis. Lumbar spondylolisthesis acquired post injury at L2-L3, already present at L4-L5 and L5-S1. Plan: At the present time, the claimant will be scheduled for L2-L3 and L3-L4 transforaminal epidural injections which are the levels directly related to the claimant's injury. At L4-L5 and LS-S1, the claimant already had spondylolisthesis which is not related to the new injury although exacerbated and probably worsened was already present which she also complains all of this was worsened by the injury. There is an EMG and Nerve Conduction Velocity Study which was ordered by Dr. that shows normal NCV and normal needle EMG which was performed at Rehabilitation Medicine and Pain Clinic. Evaluator would rather have a more extensive EMG and Nerve

Conduction Velocity Study to have better understanding of the claimant's radicular pattern. At the present time, we will go ahead and order left L2-L3 and L3-L4 transforaminal epidural injections as these are the levels that the claimant herniated during the injury. If this does not give benefit, the claimant should have L4-L5 and L5-S1 performed as well for diagnostic and therapeutic purposes. At the present time, there should not be any dispute of the L2-L3 and L4-L5 levels which have herniated post injury. They were not herniated prior to the injury. A TENS unit has been ordered.

12-29-08 DC., DWC-73: Claimant was taken off work from 12-29-08.

1-19-09 DC., DWC-73: Claimant was taken off work from 1-19-09.

1-19-09 MD., Claimant presents with numbness, chronic intractable pain syndrome, and severe cramps. Impression: lumbar disc herniation. Lumbar spondylosis. Lumbar spinal canal stenosis. Lumbar spondylolisthesis acquired post injury at L2-L3, already present at L4-L5 and L5-S1. Plan: Evaluator is awaiting approval from the insurance for ESI.

2-9-09 DC., DWC-73: Claimant was returned to work from 2-9-09 through 3-16-09 with restrictions.

2-12-09 MD., Claimant still having pain in her back. Diagnosis: multilevel disc herniations. Plan: Claimant was offered a surgical evaluation. Claimant was prescribed with Lortab.

2-24-09 MD., Performed a Designated Doctor Examination. The claimant's compensable injury is soft tissue contusion of the lower back and lumbar strain. The claimant clearly had severe degenerative multilevel, lumbar spine disease the day of the fall. The claimant was seen on xx/xx/xx in the Hospital Emergency room . The exam was essentially normal, both back and neurologic. Lumbar spine x-rays at that time revealed extensive degenerative changes as noted on the reports from Hospital dated xx/xx/xx, lumbar spine and pelvis. Furthermore, the physical examination is not consistent. As noted in Dr. 's notes, the claimant has straight leg raise testing on the left side with diminished sensation and diminished strength in a dermatomal pattern, On today's exam the claimant has stocking glove diminished sensation in the right lower extremity. The nerve conduction studies and EMGs likewise were normal. The claimant has neither muscle atrophy nor loss of any relevant reflexes at this time Based on the above; the extent of the employee's compensable injury is limited to soft tissue contusion of the lower back and lumbar strain.

3-16-09 DC., DWC-73: Claimant was taken off work from 3-16-09.

3-19-09 MD., Claimant still having pain in my back. Diagnosis: multilevel disc herniations. Plan: Claimant was offered a surgical evaluation. Claimant was prescribed with Lortab.

4-22-09 DC., DWC-73: Claimant was taken off work from 4-22-09.

4-27-09 MD., The claimant's chief complaint is lower back pain, left lower extremity numbness, chronic intractable pain syndrome. Impression: lower back pain syndrome, lumbar radiculopathy, lumbar disc herniation, history of spondylolisthesis, lumbar spinal canal stenosis, chronic intractable pain syndrome, lumbar spondylosis. Plan: Claimant was prescribed Norco and Zanaflex.

6-1-09 MD., The claimant's chief complaint is lower back pain, left lower extremity numbness, chronic intractable pain syndrome. Impression: lower back pain syndrome, lumbar radiculopathy, lumbar disc herniation, history of spondylolisthesis, lumbar spinal canal stenosis, chronic intractable pain syndrome, lumbar spondylosis. Plan: Claimant was switched to Lortab and Amrix.

6-8-09 DC., DWC-73: Claimant was taken off work from 6-8-09.

6-25-09 MD., Performed a Designated Doctor Examination. It is the evaluator's opinion that it is not medically probable that the disk herniations were a part of the original compensable injury of xx/xx/xx. The claimant had undergone MRI on October 24, 2007, which showed significant disk disease throughout the lumbar spine from L1, L2, L3, L4, L5, and S1. The claimant underwent an x-ray in the emergency room on xx/xx/xxxx, indexed event which showed degenerative changes to the SI joints, bilateral. Facet arthropathy L5 and S1 on the pelvis x-rays. The lumbar spine x-rays done xx/xx/xxxx, show extensive lumbar spine degenerative changes with significant changes at L2-L3, L4-L5, L5-S1, and bilateral facet arthropathy to the level of L5-S1. These changes were noted on the date of the injury. The fact that the claimant underwent an MRI September 18, 2008, which showed advancement of this disease, is of no surprise. The claimant has degenerative lumbosacral disease which is an ordinary disease of life. There has been no medical evidence submitted that the disk herniations were part of that compensable injury on xx/xx/xxxx. Furthermore, the exam, report done in the emergency room on xx/xx/xxxx, by Dr. states, "The back and extremities are normal. She is tenderness to palpation in her lower back, but there is good range of motion. There is good range of motion to the hips. She is able to stand and walk, but has some back pain." The neurologic exam states, "Motor normal. Reflexes normal." Subsequent to the injury, on xx/xx/xx, the claimant underwent testing including NCV/EMGs. The results are normal. The claimant also went to Chiropractic Clinic on May 16, 2008. She indicated she had no prior history or prior complaints, and the neurologic examination at that time was unremarkable. It is medically improbable that the disk herniations occurred on xx/xx/xxxx in the setting of chronic degenerative disease of the lumbar spine, including L1, L2, L3, L4, L5, and S1. Furthermore, the claimant's statement that she had no prior pain is clearly dishonest. If the claimant had no prior pain, why did she have an MRI October 24, 2007, ordered by Dr. where it states that the history is Low back pain, bilateral hip, and leg pain. It is the evaluator's belief that

the claimant lumbar spine was not asymptomatic prior to her work injury, because she had an MRI ordered by Dr. on October 24, 2007, where in the history is noted to be low back pain. Bilateral hip pain and leg pain." Furthermore, the only symptom the claimant has at this time is pain. No objective medical evidence has been submitted in the entirety of the medical record to document any physical examination findings consistent with her lumbar degenerative disease. She has no muscle atrophy nor does she have any evidence of injury on NCV/EMGs. It is not likely that her fall worsened the preexisting bulges into herniations. If the preexisting bulges had been worsened into herniations that day, she would have had more physical findings the day of the indexed event – xx/xx/xx. When seen in the emergency room by Dr. on xx/xx/xxxx, and shortly thereafter by Dr. on May 16, 2008, neurologic exam were reported as unremarkable by both physicians. There is no medical evidence to suggest that the preexisting bulges turned into herniations on the day of the indexed event. The fact that she could perform her duties prior to the injury but not able to perform them subsequent to the injury makes no sense based on the medical record as submitted and the physical examination on February 24, 2009. Evaluator does not believe that her degenerative changes were asymptomatic and there is medical evidence that has been.

7-3-09 DC., DWC-73: Claimant was taken off work from 7-3-09.

7-13-09 MD., The claimant's chief complaint is lower back pain, left lower extremity numbness, chronic intractable pain syndrome. Impression: lower back pain syndrome, lumbar radiculopathy, lumbar disc herniation, history of spondylolisthesis, lumbar spinal canal stenosis, chronic intractable pain syndrome, lumbar spondylosis. Plan: Claimant was switch to Darvocet and Skelaxin. Claimant was prescribed Kadian. DWC-73: Claimant was taken off work from 7-20-09.

7-20-09 MD., Claimant still having pain in her back. Diagnosis: multilevel disc herniations. Plan: Claimant will await the evaluator by Dr.

8-7-09 MD., Claimant complains of low back pain. Claimant states she did not have pain in her right lower extremity prior to the 5-12-08 incident. Diagnosis: Tissue contusion, lumbar spine, lumbar strain/sprain. Plan: Recommended an MRI of the lumbar spine. DWC-73: Claimant was taken off work from 8-7-09.

8-17-09 MD., The claimant's chief complaint is lower back pain, left lower extremity numbness, chronic intractable pain syndrome. Impression: lower back pain syndrome, lumbar radiculopathy, lumbar disc herniation, history of spondylolisthesis, lumbar spinal canal stenosis, chronic intractable pain syndrome, lumbar spondylosis. Plan: Refilled current medications.

8-26-09 MD., performed a Utilization Review. It was his opinion that the claimant should have undergone adequate rehabilitative therapy by now, over xxxx after the alleged injury date.

8-31-09 MD., DWC-73: Claimant was taken off work from 8-31-09.

8-31-09 MD., Claimant still having pain in her back. Diagnosis: multilevel disc herniations. Plan: Claimant will follow up with Dr.

9-8-09 MD., performed a Utilization Review. The evaluator noted the claimant has chronic radiating low back pain. The claimant is noted to have extensive supervised rehab more proximal to the date of injury. The claimant was treatment with multiple physicians since the date of injury. The claimant is reasonably expected to have reached independence with a home exercise program quite a long time ago.

9-11-09 MD., DWC-73: Claimant was taken off work from 9-11-09.

The claimant has a prior MRI dated 10-24-07, which showed spondylosis, disc disease, and posterior element hypertrophy along with Migration in alignment resulting in multi-level canal narrowing/stenosis and foraminal narrowing.

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

MEDICAL RECORDS REFLECT A CLAIMANT WHO SUSTAINED A LUMBAR STRAIN. THE CLAIMANT HAS BEEN TREATED WITH MEDICATIONS AND SIGNIFICANT SUPERVISED THERAPY. AT THIS JUNCTURE, 12 SUPERVISED REHABILITATION SESSIONS (TO INCLUDE 97110, 97124, 97140, 97530, 97113, 97035, G0283, 97116, 97010) WOULD NOT BE REASONABLE, AS THE CLAIMANT HAS UNDERGONE THERAPY FOR A PROLONGED PERIOD WITHOUT ANY LASTING IMPROVEMENT. IT IS NOT CLEAR WHAT PHYSICAL THERAPY WILL BRING AT THIS JUNCTURE OVER A YEAR AFTER THE ORIGINAL INJURY. THERE IS NO INDICATION WHY THE CLAIMANT IS NOT PERFORMING A HOME EXERCISE PROGRAM. THEREFORE, THE MEDICAL NECESSITY OF 12 SUPERVISED REHABILITATION SESSIONS IS NOT ESTABLISHED AS MEDICALLY NECESSARY.

ODG-TWC, last update 9-28-09 Occupational Disorders of the Low Back – 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. 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; & Aquatic therapy. [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), 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. (Arribas, 2009)

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) Practitioners must be cautious when implementing the wait-and-see approach for LBP, and once medical clearance has been obtained, patients should be advised to keep as active as possible. Patients presenting with high fear avoidance characteristics should have these concerns addressed aggressively to prevent long-term disability, and they should be encouraged to promote the resumption of physical activity. (Hanney, 2009)

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. (Luijsterburg, 2007) (Luijsterburg2, 2007) (Price, 2005) (Vad, 2002) (Smeal, 2004)

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. (Ostelo, 2009)

ODG Physical therapy Guidelines:

Lumbar sprains and strains (ICD9 847.2): 10 visits over 8 weeks

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)