

# I-Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/01/2009

**IRO CASE #:**

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

Outpatient physical therapy three times a week for two weeks consisting of therapeutic exercises, manual therapy, neuromuscular reeducation and electrical stimulation, not to exceed more than 4 units per session as related to the lumbar spine

**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  
Board Certified in Electrodiagnostic Medicine

**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**

Adverse Determination Letters, 7/28/09, 8/6/09  
ODG Guidelines and Treatment Guidelines  
Accuhealth Preauth Request Form, 7/27/09  
Physical Assessment Evaluation and Treatment Plan, 7/21/09  
MD, 3/18/09, 6/26/09, 8/10/09, 7/29/09, 3/31/09, 4/8/09, 4/22/09, 5/13/09, 6/11/09  
MD, 8/5/09  
MRI Lumbar Spine, 8/29/05  
MRI Thoracic Spine, 9/8/05  
MRI Right Knee, 9/8/05  
Employee's Report of Injury, xx/xx/xx  
FCE, 9/12/05  
MA, LPC, 9/27/05  
FCE, 5/11/06  
Caudal Epidural Steroid Block, 3/13/06  
MD, 8/29/06, 2/14/07, 3/8/07, 5/1/07, 6/15/07, 7/26/07, 8/13/08  
DO, 2/8/07, 2/22/07, 3/1/07, 3/15/07  
MD, 8/8/06

**PATIENT CLINICAL HISTORY SUMMARY**

This woman was reportedly injured in xx/xxxx when she was hit by a truck, injuring her knee and back. She had therapy, epidural injections and knee surgery. She had a prior (1981) cerebral aneurysm with varying descriptions of her hemiparesis. Her MRI in 2005 showed facet arthropathy compromising the neural foramen from L3-L5, and some in the thoracic region. She had a series of FCEs in 2005 and 2006. She was in work hardening in 2005. The 2006 report says that "given her CVA related deficits it is unlikely she would or should qualify for in excess of a light PDL." She had another FCE on 3/31/09. Dr. felt in April 2006 that she did not require further treatment. Dr. appealed the denial of her therapies stating she was deconditioned and needed a home exercise program.

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

This patient has had treatment for her chronic back pain, including participation in a work hardening program. After her 2006 FCE, her therapists did not advise further treatment. Dr. agreed in his report of 4/17/06 that this patient did not require further treatment. Dr. has appealed the denial of physical therapy stating the patient was deconditioned and needed a home exercise program. While the ODG does not recommend therapies after completion of work hardening programs, it does approve supervised exercise (therapies) as a means of managing chronic pain. The program can include manual therapies as a component. As such, the reviewer finds that the 6 sessions over 2 weeks is justified in this case. The providers have noted that the therapy shall be directed at any fear she has and as a means of her developing a successful home program. The reviewer finds that medical necessity exists for outpatient physical therapy three times a week for two weeks consisting of therapeutic exercises, manual therapy, neuromuscular reeducation and electrical stimulation, not to exceed more than 4 units per session as related to the lumbar spine.

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.

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.

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)...

#### 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

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

10 visits over 5 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5)

9 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...

Work conditioning (See also Procedure Summary entry)

10 visits over 8 weeks

### Exercise

Recommended for treatment and for prevention. There is strong evidence that exercise reduces disability duration in employees with low back pain. In acute back pain, exercise therapy may be effective, whereas in subacute back pain, exercises with a graded activity program, and in chronic back pain, intensive exercising, should be recommended. Exercise programs aimed at improving general endurance (aerobic fitness) and muscular strength (especially of the back and abdomen) have been shown to benefit patients with acute low back problems. So far, it appears that the key to success in the treatment of LBP is physical activity in any form, rather than through any specific activity. One of the problems with exercise, however, is that it is seldom defined in various research studies and its efficacy is seldom reported in any change in status, other than subjective complaints. If exercise is prescribed a therapeutic tool, some documentation of progress should be expected. While a home exercise program is of course recommended, more elaborate personal care where outcomes are not monitored by a health professional, such as gym memberships or advanced home exercise equipment, may not be covered under this guideline, although temporary transitional exercise programs may be appropriate for patients who need more supervision....

A recent meta-analysis concluded that exercise therapy which consists of individually designed programs, including stretching and strengthening, and delivered with supervision, improves pain and function in chronic nonspecific low back pain. The study found improved pain scores for individually designed programs (5.4 points), supervised home exercise (6.1 points), group (4.8 points), and individually supervised programs (5.9 points) compared with home exercises only. High-dose exercise programs fared better than low-dose exercise programs (1.8 points). Interventions that included additional conservative care were better (5.1 points). A model including these most effective intervention characteristics would be expected to demonstrate important improvement in pain (18.1 points compared with no treatment and 13.0 points compared with other conservative treatment) and small improvement in function (5.5 points compared with no treatment and 2.7 points compared with other conservative treatment). (Hayden, 2005) (Hayden2, 2005) One recent trial found that the best exercise program required that patients continue therapeutic activities even if their pain increased, as opposed to stopping activities due to pain, which supports the hypothesis that fear of pain may be more disabling than pain itself. When pain intensity is used to determine the intensity of the exercises, it may lead to restrictive recommendations regarding activity and work, and it seems to increase behaviors such as taking pain-killers, seeking health care, stopping work, limping, guarding, and talking about pain. (Kool, 2005) 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. (Ostelo-Cochrane, 2002) Multiple studies have shown that patients with a high level of fear-avoidance do much better in a supervised 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 supervised exercise. (Fritz, 2001) (Fritz, 2002) (George, 2003) (Klaber, 2004) (Hicks, 2005)

A spinal stabilization program (exercises that emphasize strengthening of various muscles supporting the spine) is more effective than standard physical therapy sessions in which no exercises are prescribed. Manual therapy may be appropriate as a pain reducing modality, but it should not be used as an isolated modality because it does not reduce disability. (The

only abnormality that is present in all back problems is lumbar extensor weakness.) (Goldby-Spine, 2006) A recent trial concluded that active physical treatment, cognitive-behavioral treatment, and the two combined each resulted in equally significant improvement, much better compared to no treatment. (The cognitive treatment focused on encouraging increased physical activity.) (Smeets, 2006) A recently published well respected international guideline, the "European Guidelines," recommend supervised exercise therapy as a first-line treatment in the management of chronic low back pain. The use of a cognitive-behavioural approach, in which graded exercises are performed, using exercise quotas, is advised. Group exercise is an attractive option for treating large numbers of patients at low cost. They do not give recommendations on the specific type of exercise to be undertaken (strengthening/muscle conditioning, aerobic, McKenzie, flexion exercises, etc.) because that may be best determined by the exercise-preferences of both the patient and therapist. Better symptom relief is achieved with directional preference exercise. (Long, 2004) This study found no effect of nonspecific physical exercise on recovery from LBP in men and women, but the exercises measured were not specific back strengthening or stretching exercises...

When used for treatment, exercise diminishes disability and pain severity while improving fitness and occupational status in patients who have subacute, recurrent, or chronic low back pain, but patients with acute low back pain are usually advised to continue their everyday activities to the greatest extent possible rather than to start an exercise program. Supervision is crucial to the efficacy of exercise programs. Whether general or specific exercises are preferable is unclear, and neither is there clear evidence that one-on-one sessions are superior to group sessions. (Henchoz, 2008) An educational technique known as the Alexander technique, along with exercise, is effective for long-term relief of low back pain, according to the results of a randomized trial reported in the BMJ. (Little, 2008) Employees who use weight training to ease low back pain are better off than those who choose other forms of exercise, according to a recent study, which found a 60% improvement in pain and function levels from a 16-week exercise program of resistance training using dumbbells, barbells, and other load-bearing exercise equipment, versus 12% from aerobic training, jogging, using a treadmill or an elliptical machine. (Kell, 2009) 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)

#### **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)