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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 02/08/2010

IRO CASE #:

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

Physical Therapy 3 x 3 Lumbar 97001, 97110, 97112, 97113

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 11-06-09 Lumbar MRI read by Dr.
- o 12-14-09 Initial Medical Progress Notes from Dr.
- o 12-14-09 Treatment plan - from Dr.
- o 12-14-09 Office visit data, unsigned
- o 12-21-09 Utilization Review referral from Dr.
- o 12-28-09 Medical Progress Note from MD
- o 12-29-09 Notification of Adverse Determination
- o 12-30-09 Physical Therapy Evaluation from PT
- o 12-31-09 Utilization Review referral from Dr.
- o 01-13-10 Notification of Reconsideration Determination
- o 01-13-10 Request for IRO from the claimant
- o 01-19-10 Notice of Case Assignment of IRO from TDI
- o 01-19-10 Confirmation of Receipt of IRO, TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews, the patient is a employee who sustained an industrial injury to the low back on xx/xx/xx when lifting boxes of tiles. Lumbar MRI was performed on November 6, 2009 and given impression, L5-S1: 8 mm broad central disc protrusion/extrusion impinging on the thecal sac.

According to the medical report of December 14, 2009 the patient was transferring from another provider as he was unhappy with the service. He works for a carpet and tile company. He reports discomfort and numbness to the left leg. He reports having completed four weeks of PT without improvement after which he was sent for MRI. He reports a severe level of pain and that

nothing was ever done, so he is changing offices. He is 5' 6" and 160 pounds (BMI of 25.82). He has normal blood pressure. He is using Tramadol HCL-acetaminophen and Methocarbamol. He appears uncomfortable and paces the floor. He is given a diagnosis of L5-S1 radiculopathy, left sciatica, lumbosacral strain and lifting injury. He is prescribed Lortab, Flexeril, Naproxen. He will be ordered PT and referred for a neurosurgical evaluation.

On December 21, 2009 nine sessions of PT (3 x 3) were requested with PT Evaluation (97001), Therapeutic Exercises (97110), Neuromuscular Reeducation (97112), and Aquatic Therapy (97113) each session.

The patient was reevaluated on December 28, 2009 for left low back pain and left sciatica. He reports numbness in the left buttock and between the ankle and heel. He denies any weakness. He called the carrier to see when he can start PT and was told the approval process is not completed yet.

The patient was assessed in PT on December 30, 2009. He reports the pain started when lifting a table. He felt a pull and pain the following day. His symptoms are minimally improved. He denies any paresthesias. He rates his pain as 7/10. Flexion is to 30 degrees and extension to 15 degrees. Upper abdominal strength is 4-/5, multifidus strength is 3-/5 left and right. He has sciatic notch pain with left straight leg raise. Sensation is intact. There is tenderness in the lumbar region. Recommendation is for 12 sessions of PT or until goals are met. Goals include lifting 35 pounds x 10 reps and carrying 35 pounds 25 feet with no pain.

Request for nine sessions of physical therapy to the lumbar spine with modalities was considered in review on December 29, 2009 with recommendation for non-certification. No PT reports were available for review. MRI showed L5-S1 8 mm broad central disc protrusion/extrusion impinging the thecal sac. A rationale for the request was not stated. Attempts were made for a discussion with the provider but were not realized. ODG supports 10 sessions of PT over 8 weeks for the patient's diagnosis. Rationale for denial states the patient was not satisfied with care at previous office; however, the amount of PT provided to date and the results were not reported. Guidelines recommend a trial of 6 visits.

The provider requested reconsideration. However, no additional medical reports were submitted.

Request for reconsideration, nine sessions of physical therapy to the lumbar spine with modalities was considered in review on January 13, 2010 with recommendation for non-certification. Three weeks of PT were requested with the number of sessions completed not stated, with no significant improvement. A peer discussion was attempted but not realized. The patient is reporting low back pain and left lower extremity numbness especially in the buttocks area. Request is for nine visits. However, there are no serial therapy progress reports that objectively document the clinical and functional response of the patient from the previously rendered sessions. The clinical information submitted for review did not provide the therapy goals that delineate the endpoints of care. A complete physical examination of the affected body part was not submitted for review. Response to medication was not given emphasis. Records provided do not indicate a clear statement why an independent home exercise program would be insufficient to address any remaining functional deficits. He has an unknown number of PT visits. As guidelines indicate, when treatment duration exceeds the recommendation, exceptional factors should be noted. There is none in the records submitted that mention such exceptional factors. Additional relevant information from a peer-to-peer contact is needed to substantiate the medical necessity of this request.

Request was made for an IRO.

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

The patient presents approximately 11 weeks post injury to a new provider as he was not satisfied with the services provided at the prior office. He reports having completed four weeks of PT without improvement after which he was sent for MRI. MRI showed an 8 mm broad central disc protrusion/extrusion at L5-S1 impinging on the thecal sac. He is 5' 6" and 160 pounds. He is using Tramadol HCL-acetaminophen and Methocarbamol. He appears uncomfortable and paces the floor. He denies any weakness. He is given a diagnosis of L5-S1 radiculopathy, left sciatica, lumbosacral strain and lifting injury. He is prescribed Lortab, Flexeril, Naproxen. He will be ordered PT and referred for a neurosurgical evaluation. He is assessed in PT: He rates his pain as 7/10. Flexion is to 30 degrees and extension to 15 degrees. Upper abdominal strength is 4-/5, multifidus strength is 3-/5 left and right. He has sciatic notch pain with left straight leg raise. Sensation is intact. There is tenderness in the lumbar region. Recommendation is for 12 sessions of PT or until goals are met. Goals include lifting 35 pounds x 10 reps and carrying 35 pounds 25 feet with no pain. The provider requests nine sessions of PT to include each visit, a reevaluation, therapeutic exercises, neuromuscular reeducation and aquatic therapy.

The patient appears to have attended 9-12 visits of PT. ODG guidelines recommend 10 visits for intervertebral disc disorders without myelopathy. The patient remains only marginally improved and has functional deficits on examination. MRI scan shows a large disc herniation at the L5-S1 level which corresponds to the patient's symptoms. A neurosurgical evaluation has been recommended. Given poor response to prior physical therapy after attending the recommended number of therapy sessions for this diagnosis, there is no justification for additional therapy at this time despite the patient's noted ongoing complaints. Therefore, my recommendation is to agree with the prior non-certification for Physical Therapy 3 x 3 Lumbar 97001, 97110, 97112, 97113.

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
- X ___ 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 (12-30-2009) Low Back Chapter - 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.

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. (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.

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.

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.

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

Sprains and strains of sacroiliac region (ICD9 846):

Medical treatment: 10 visits over 8 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

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

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

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

Intervertebral disc disorder with myelopathy (ICD9 722.7)

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis (ICD9 724.0):

10 visits over 8 weeks

See 722.1 for post-surgical visits

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):

10-12 visits over 8 weeks

See 722.1 for post-surgical visits

Curvature of spine (ICD9 737)

12 visits over 10 weeks

See 722.1 for post-surgical visits

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

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

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

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Work conditioning (See also Procedure Summary entry):

10 visits over 8 weeks