

# P&S Network, Inc.

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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, 12 sessions

### **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 11-23-09 Progress report from Dr.
- o 12-15-09 Lumbar MRI report read by Dr.
- o 12-07-09 Assessment report with request for MRI from Dr.
- o 12-01-09 Initial Evaluation notes from Dr.
- o 12-21-09 Injection Scheduling LESI from Dr.
- o 12-21-09 Assessment letter - request for LESI from Dr.
- o 12-28-09 Physical Therapy Evaluation from Dr.
- o 12-30-09 Fax cover-request for PT from Clinic
- o 12-30-09 Pre-Auth Request Form for LESI from Sports Med Center
- o 12-31-09 Initial Adverse Determination Letter
- o 01-05-10 Fax request for LESI from Dr.
- o 01-06-10 Fax request for PT x 12 from Dr.
- o 01-06-10 Request for Reconsideration from Dr.
- o 01-13-10 Adverse Determination Letter for Reconsideration
- o 01-21-10 Confirmation of Receipt of IRO from TDI
- o 01-21-10 Request for IRO from the claimant
- o 01-22-10 Notice of Case Assignment of IRO from TDI
- o 01-28-10 Letter from Dr.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records and prior reviews the patient sustained an industrial injury to the low back on xx/xx/xx while pulling bins during a flight.

The patient was reassessed orthopedically. She has a history of disc herniations L3-4 through L5-S1 and has been followed for low back pain. She was doing fine but is reporting flare-up with pulling on an ice bucket at work in November. She went to ER and had two x-rays and an injection. She was told the x-rays are normal. She has some radiation into the left hip and thigh. She is using ibuprofen and Flexeril. She will attend PT and undergo MRI.

The patient was assessed in PT on December 1, 2009. She has recurring back pain from reaching and pulling ice bags at work. She has difficulty with ADLs. Flexion is to 40 degrees and extension to 5 degrees. Spinal extensor and abdominal strength is 3/5. There is grade II joint pain with maneuvers. Straight leg raise is positive on the left. Right hip motion is painful. Her pain level is 3/10 at rest and 6/10 with activities. 12 sessions of therapy with passive and active content is planned.

At reevaluation on December 7, 2009 the physician noted unchanged back symptoms. She is using ibuprofen and Flexeril. She is having some lower extremity problems with occasional ache in the hip and thigh and some pain in both knees. She has done well with ESIs in the past and these will be considered along with an MRI.

MRI of December 15, 2009 revealed, multilevel degenerative disc disease in the lumbar spine with a left foraminal protrusion at L3-4 posteriorly displacing the exiting left L3 nerve root and a left paracentral protrusion likely impinging upon the traversing left L4 nerves within the anterolateral thecal sac. No central canal stenosis was seen. There was a broad based right paracentral protrusion at L5-S1 causing mild effacement of the proximal descending right S1 nerve root sleeve with no significant mass-effect on the thecal sac. There was bilateral lateral recess stenosis at L4-5 without definite impingement on the exiting L4 nerve roots and a concentric annular bulge without focal protrusion. There was minimal central canal stenosis.

At reevaluation on December 21, 2009 the provider noted some annular tearing impinging on the left L4 nerve root and mild bilateral recess stenosis per imaging findings. Diagnosis is updated to, status post injury on the job with low back pain, bilateral lower extremity pain, left L3-4 HNP, L4-5 HNP with lateral recess stenosis and L5-S1 HNP with left foraminal stenosis. Recommendation is for ESI as she obtained about one year relief with an epidural in 2007.

The patient was reevaluated on December 28, 2009 for low back pain and sensations of burning and tingling into the left leg described as 5-8/10 in intensity. Flexion is to 20 degrees and extension to 5 degrees. Abdominal strength is 3+/5. She has moderate pain, decreased motion, decreased abdominal strength, decreased tolerance for standing and walking and for lifting and pushing activities. She would benefit from ACTIVE rehabilitation and will begin Phase I of her active rehabilitation program. Manual therapy and modalities will also be used for motion and pain relief.

On December 30, 2009 request was made for a caudal lumbar epidural injection and 12 sessions of PT.

On January 6, 2010 request was again made for 12 sessions of active physical rehabilitation.

Request for 12 sessions of physical therapy was considered in review on December 31, 2009 with recommendation for non-certification. The claimant reports low back pain and burning and tingling sensations into the left foot. Examination notes restricted range of motion and tenderness to palpation. The therapist recommends active rehabilitation and that the claimant begins in Phase I protocol. The claimant has attended 12 sessions of PT to date. ODG supports 10 visits over 8 weeks for the claimant's diagnosis. The provider was unable to provide any helpful information. There are no exam findings noted and the provider was not aware that the claimant had already attended 12 sessions of PT.

Request for reconsideration was made on January 6, 2010. The patient can still demonstrate improvements in AROM, strength and tolerance and performance of sitting, standing, walking, bending, squatting, lifting, pushing and pulling. She has not yet reached her pre-injury functional level. She can improve function further which will allow for return to work. It is reasonable that she have a short course of more aggressive PT to address her functional deficits.

Request for reconsideration of 12 sessions of physical therapy was considered in review on January 13, 2010 with recommendation for non-certification. The patient has already attended 12 sessions of PT. A request for epidural injection and additional PT have not been certified. The provider argues that the patient needs additional therapy for improvement in ROM, strength and tolerance since she has not yet attained pre-injury level. He feels the claimant needs further supervised therapy in a structured exercise program. The program he outlines is one primarily of therapeutic exercises, stretching and joint mobilization with modalities. In discussion with the provider's colleague, it was clarified that nothing in the submitted documentation indicates that exceeding the guideline recommendation for 10 visits is medically necessary or appropriate for this claimant.

The provider submitted an additional letter dated January 27, 2010 again noting the patient continues to have functional deficits and could benefit from additional formal therapy.

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

The patient has been followed for several years for chronic back pain and pre-existing degenerative changes noted on MRI as mild displacement of the left L3 nerve root, no impingement on the L4 or L5 nerve roots. She had a flare-up in November 2009 and was seen in ER where x-rays and an injection were provided. The x-rays were reportedly unremarkable. She returned to her provider on November 23, 2009 where she was examined and was sent to PT. At initial PT assessment on December 1, 2009 she reportedly has difficulty with ADLs, flexion to 40 degrees, extension to 5 degrees and spinal extensor and abdominal strength of 3/5. Straight leg raise was positive on the left and right hip motion painful. Her pain level was 3/10 at rest and 6/10 with activities.

The physician saw her December 7, 2009 and she was unchanged. A physical examination was not done this visit. 12 sessions of therapy with passive and active content were provided. There is no PT note or reassessment found. Per physician reevaluation of December 21, 2009 the diagnosis is updated to status post injury on the job with low back pain, bilateral lower extremity pain, left L3-4 HNP, L4-5 HNP with lateral recess stenosis and L5-S1 HNP with left foraminal stenosis. The physician does not include a physical examination this visit. Recommendation was for an ESI which apparently was not authorized. The most recent PT reevaluation of December 28, 2009 was done by a physician and notes persisting low back pain and sensations of burning and tingling into the left leg described as 5-8/10 in intensity, flexion to 20 degrees, extension to 5 degrees and abdominal strength of 3+/5. The provider desires active therapy but includes passive modalities in the request.

Per the first line non-certification, ODG supports 10 visits over 8 weeks for the claimant's diagnosis. The provider was unable to provide any helpful information in conversation and there were no examination findings noted. Additionally, the provider was not aware that the claimant had already attended 12 sessions of PT.

Per the second line non-certification, the patient had already attended 12 sessions of PT. In discussion with the provider's colleague, it was clarified that nothing in the submitted documentation indicates that exceeding the guideline recommendation for 10 visits is medically necessary or appropriate for this claimant.

The provider argues that the patient needs additional therapy for improvement in ROM, strength and tolerance since she has not yet attained pre-injury level. He feels the claimant needs further supervised therapy in a structured exercise program. The program he outlines is one primarily of therapeutic exercises, stretching and joint mobilization with modalities. However, the request also includes passive modalities such as hot-cold packs, massage, and ultrasound.

The patient does have continuing deficits. In fact she appears to have less range of motion and strength on December 28, 2009 than December 1, 2009. No PT notes are available to document compliance, instruction in HEP or the patient's response to the PT treatment. Given the patient has chronic back pain and has been under treatment with this physician for a number of years prior to the current re-injury, and given that HEP instruction is a standard protocol, and given there is no report of a contradiction to a HEP found, the provider's rationale for an extended program of PT exceeding the guideline recommendation for 10 visits falls short. It is felt that an extended program of 12 sessions of PT would not be medically necessary or supported by ODG guidelines for re-instruction in a HEP. Therefore, my recommendation is to agree with the previous non-certification for 12 sessions of physical therapy.

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