CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: 8-1-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Active Physical Rehabilitation x 4 sessions (97110, 97140)

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

Chiropractor

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 6-1-11 DC., office visit.
- 6-23-11 UR review performed by MD.
- 7-12-11 DC., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

11-7-02 lumbar myelogram showed that an unusual finding would be that one of his upper screws was found to be broken in half.

2-16-10 Lumbar spine flexion/extension views shows status post interbody and posterior spinal fusion from L3 through S1 with good bony fusion present. No evidence of transitional instability. Fractured right 3 screw on a chronic basis.

1-10-07 EMG/NCS of the lower extremities performed by MD., showed chronic bilateral L5 radiculopathy, slightly worse on the right. Moderate right deep peroneal sensory neuropathy, consistent with entrapment at the foot.

6-1-11, DC., the claimant is experiencing acute flare up of his pain which he states started 4 days ago. He states no new trauma. The pain extends up into the neck area as primarily muscle coming from the low back. He states increased pain in his right leg. He rates his pain as 9/10. He continues with the use of medications, portable TENS unit which helps temporarily. He has tried stretching, moist heat and soaks at home. On exam, the claimant has positive SLR at 40 degrees bilaterally. Yeomans test is positive. Achilles reflex is absent bilaterally. Patellar reflexes are +1. Range of motion is decreased. Impression: Status post lumbar fusion L3 - S1, lumbar disc derangement, lumbar radiculopathy. Plan: Submit for a short course of physical therapy due to recent fair. The evaluator recommended a short trial course of lumbar manipulation for 6 sessions.

6-23-11 UR review performed by MD., notes the claimant has a post-laminectomy syndrome and has had extended treatment over the years. The office note of 6-1-11 had proposed manipulation therapy. The patient should have adequate training already in a home exercise program to be able to carry on with this program without further formal instruction. The specific medication regimen utilized was not discussed. The request is not validated by these records and the ODG would only support the use of

the home exercise regimen at this time post injury and post surgery. Case discussed with Dr. on 6-22-11 at 14:05. States the home exercise program is flaring the back pain. He has not been seen recently. There were no changes neurologically.

7-12-11 DC., performed a Utilization Review. She noted that this claimant had had extensive treatment for this injury that occurred over 14 years ago including multiple surgeries, ESIs and chronic pain management program as well as physical therapy. The patient should have had sufficient formal therapy with instruction in and transition to a home exercise program. Additional supervised therapy is not medically necessary. She discussed the case with Dr. No additional pertinent information was provided to change the determination. The request remains non- certified.

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

RECORDS REVIEW SHOWS THE CLAIMANT PRESENTED TO THE PROVIDER WITH A FLARE-UP OF LOWER BACK PAIN WITH RADIATION FOLLOWING EXTENSIVE POST-SURGICAL REHABILITATION AND INJECTION THERAPY. THE PROVIDER NOTES THAT THE CLAIMANT'S HOME EXERCISE/THERAPY PROGRAM HAD BEEN ATTEMPTED AND FAILED, AND SERVED TO INCREASE SYMPTOMS. TWO PRIOR UTILIZATION REVIEWS WHICH INCLUDED PEER CONVERSATIONS RECOMMENDED NO ADDITIONAL THERAPY WAS WARRANTED, AS THE CLAIMANT SHOULD HAVE BEEN WELL-VERSED IN HIS HOME PROGRAM AT THIS POINT. HOWEVER, IN THIS CASE, IT IS CLEARLY DOCUMENTED THAT THE CLAIMANT FAILED TO PROGRESS WITH A SELF-DIRECTED PROGRAM AND PRESENTED WITH A SEVERE FLARE-UP. GUIDELINES PROVIDE THAT A SHORT RETURN TO THERAPY (1-2 VISITS, NO MORE FREQUENTLY THAN 4-6 MONTHS) CAN BE HELPFUL DURING PERIODS OF ACUTE SYMPTOMS IN ORDER TO MODIFY OR MONITOR A CLAIMANT'S HOME PROGRAM. THE REQUEST IS FOR ACTIVE CHIROPRACTIC PHYSICAL REHABILITATION AND DOES EXCEED THE RECOMMENDATIONS OF EVIDENCE-BASED MEDICINE. HOWEVER, THE SPECIFICS OF THIS CASE SUPPORT A RETURN TO ACTIVE THERAPY FOR 2 SESSIONS. RECOMMEND PARTIAL CERTIFICATION OF 2 SESSIONS ACTIVE REHABILITATION AS MEDICALLY REASONABLE AND NECESSARY.

ODG-TWC, last update 7-12-11 Occupational Disorders of the Low Back – chiropractic care: Recommended as an option. Medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. For patients with chronic low back pain, manipulation may be safe and outcomes may be good, but the studies are not quite as convincing. While not proven by multiple high quality studies, a trial of manipulation for patients with radiculopathy may also be an option, when radiculopathy is not progressive, and studies support its safety. As with any conservative intervention

in the absence of definitive high quality evidence, careful attention to patient response to treatment is critical. Many passive and palliative interventions can provide relief in the short term but may risk treatment dependence without meaningful long-term benefit. Such interventions should be utilized to the extent they are aimed at facilitating return to normal functional activities, particularly work. Potential cautions or contraindications include coagulopathy, fracture, and progressive neurologic deficit. (Andersson-NEJM, 1999) (Cherkin-NEJM, 1998) (Mohseni, 1998) (Aure, 2003) (Pengel, 2002) (Assendelft-Annals, 2003) (Assendelft-Cochrane, 2003) (Cherkin-Annals, 2003) (Licciardone, 2003) (Giles, 2003) (Ferreira, 2003) (Assendelft-Cochrane, 2004) (Grunnesjo, 2004) (Bronfort, 2004) (Hoiriis, 2004) (Oliphant, 2004) (Koes, 2004) (Legorreta, 2004) (UK BEAM, 2004) (Ianuzzi, 2005) (Muller, 2005) (Licciardone, 2005) (Airaksinen, 2006) (Ernst, 2006) (Hurwitz, 2006) (Santilli, 2006) One high-quality clinical trial comparing chiropractic and physical therapy found both effective, but chiropractic was slightly more favorable for acute back pain and PT for chronic cases. (Skargren, 1998) An economic evaluation of four treatments for low-back pain (excluding pharmaceuticals) concluded that mean costs per treatment group were $369 for medical care only, $560 for chiropractic care only, $579 for chiropractic care with physical modalities, and $760 for medical care with physical therapy. This study did not compare outcome success. (Kominski, 2005) Physician consultation is more cost-effective alone than when combined with manipulative treatment; outcomes show significant improvement in both groups, but the combination group had slightly more reduction in pain and clearly higher patient satisfaction. (Niemisto, 2005) Various techniques of manipulation are done by different providers. Manipulation, as used in the above studies, is defined as a process of physiological movement which goes beyond the passive range of motion into the paraphysiological zone, which may involve high velocity with or without recoil. This form of manipulation ("diversified") is the most commonly used by chiropractors; there is another form ("flexion-distraction"), but there are limited studies. The efficacy of distraction manipulation is not well established. (Gay, 2005) Spinal manipulation has been reviewed in 4 good-quality systematic reviews, and short-term, but not long-term, improvements have been reported. (Kinkade, 2007) Patients with acute low back pain receiving recommended first-line care did not recover more quickly with the addition of diclofenac or spinal manipulative therapy, according to the results of a randomized controlled trial in the November 8 issue of *The Lancet*. (Hancock, 2007) In this study of workers' comp patients, less chiropractic care visits was significantly associated with a lower likelihood of disability recurrence and 8.6% shorter disability duration. (Wasiak, 2007) A recent RCT found pain reductions were similar in both the experimental and control groups. Outcomes were assessed daily on days 1 to 14 by patient diary and at 6 months by mailed questionnaire. Limitations of the study included inability to closely monitor patient diaries, low recruitment rate, inability to blind clinicians and patients to treatment, and use of equivalence doses as the primary outcome measure. (Jüni, 2008) *Number of Vists:* Several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. These findings question the need for extended treatment, or at least encourage the need for

reassessment after a few weeks of treatment. (Burton, 2000) (Hurwitz, 2002) (MD Consult, 2003) (Stig, 2001) (Niemsto, 2003) (Haas, 2004) (Haas2, 2004) (Descarreaux, 2004) One specific study showed a success rate of 88% by six weeks with an average total of 8.2 visits, and 3.8 more if recurrence. (Triano, 1992) Another clinical trial found that only 4 sessions of manipulation and stabilizing exercises resulted in less pain and disability than physician consultation alone. (Niemsto, 2003)

Patient Selection Criteria: The results of a recent study demonstrate that two factors - symptom duration of less than 16 days, and no symptoms extending distal to the knee - were associated with a very good outcome from early referral for spinal manipulation. After only 1-2 sessions of spinal manipulation treatment and a range of motion exercise, the success rate when both criteria were present was 85%, and when both criteria absent was only 28%. (Fritz, 2005) Other studies support using patient selection criteria, including: (1) Duration of current LBP less than 16 days; (2) Not having symptoms below the knee; (3) FABQ score less than 19 points; (4) At least one hypomobile segment in the lumbar spine; & (5) Hip internal rotation range of motion >35 degrees. (Flynn, 2002) (Niemisto, 2004) (Fritz, 2004) (Childs, 2004) (Riipinen, 2005) Patients with signs and symptoms that suggest movement restrictions of the lumbar region should be treated with joint mobilization–manipulation techniques and range of motion exercises. (Fritz-*Spine*, 2003)

Active Treatment versus Passive Modalities: Manipulation is a passive treatment, but many chiropractors also perform active treatments, and these recommendations are covered under Physical therapy (PT), as well as Education and Exercise. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases.

Current research: A recent comprehensive meta-analysis of all clinical trials of manipulation has concluded that there was good evidence for its use in acute, sub-acute, and chronic low back pain, while the evidence for use in radiculopathy was not as strong, but still positive. (Lawrence, 2008) A Delphi consensus study based on this meta-analysis has made some recommendations regarding chiropractic treatment frequency and duration. They recommend an initial trial of 6-12 visits over a 2-4 week period, and, at the midway point as well as at the end of the trial, there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. If the criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow-up course of treatment may be indicated consisting of another 4-12 visits over a 2-4 week period. According to the study, “One of the goals of any treatment plan should be to reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent strengthening and range of motion exercises, and rehabilitative exercises. Patients also need to be encouraged to return to usual activity levels despite residual pain, as well as to avoid catastrophizing and overdependence on physicians, including doctors of chiropractic.” (Globe, 2008) These recommendations are consistent with the recommendations in ODG, which suggest a trial of 6 visits, and then 12 more visits (for a total of 18) based on the results of the trial, except that the Delphi recommendations

in effect incorporate two trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24). Payors may want to consider this option for patients showing continuing improvement, based on documentation at two points during the course of therapy, allowing 24 visits in total, especially if the documentation of improvement has shown that the patient has achieved or maintained RTW. This systematic review concluded that there is moderate quality evidence that spinal manipulation is effective for the treatment of acute lumbar radiculopathy, but there is no evidence for the treatment of thoracic radiculopathy. (Leininger, 2011)

ODG Chiropractic Guidelines:
Therapeutic care –
Mild: up to 6 visits over 2 weeks
Severe:* Trial of 6 visits over 2 weeks
Severe: With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity
Elective/maintenance care – Not medically necessary
Recurrences/flare-ups – Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care

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)**