

**ReviewTex**  
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Notice of Independent Review Decision

**DATE OF REVIEW:** 2/16/12

**IRO CASE NO.:**

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

Item in dispute: Reconsideration for Physical Therapy 2 x a week for 6 weeks  
97110 97112 97535 97116

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

Board Certified in Family Medicine

**REVIEW OUTCOME**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Utilization review determination dated 01/03/12, 01/06/12
2. Soap note dated 01/27/12, 12/28/11, 11/14/11, 11/09/11, 10/27/11, 10/21/11
3. Radiographic report dated 10/10/11
4. Early compensability assessment dated 10/31/11
5. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was bending over to pick up a box and felt pain in the lower back.

Radiographic report of the lumbar spine dated 10/10/11 revealed anterolisthesis of L4 on L5 of less than 25% appears to be degenerative in etiology; multilevel degenerative disc disease and facet joint arthropathy; scoliotic deformity of the lumbar spine convex to the left; old compression fracture of T10; the lumbar spine is stable in flexion and extension. Initial soap note dated 10/21/11 indicates the patient was diagnosed with lumbar sprain. Early

compensability assessment dated 10/31/11 indicates that only non-acute degenerative changes were identified on lumbar MRI. Assessment and diagnosis reports soft tissue myofascial strain of the paravertebral musculature of the lumbar region of the spine.

Soap note dated 12/28/11 states that physical therapy is helping. Pain is rated as 3/10. On physical examination lumbar range of motion is limited with pain: flexion 120, extension 5, rotation 80, right side bend 15 and left side bend 10 degrees. Straight leg raising is negative. The patient completed at least 8 sessions of physical therapy.

Initial request for physical therapy 2 x week x 6 weeks was non-certified on 01/03/12 noting that the patient was discharged from PT because all goals were met for range of motion and strength. The patient lifts appropriate, can walk on treadmill 30 minutes and has no further therapist A.P. wants to work toward. The denial was upheld on appeal dated 01/06/12 noting that the claimant is with a working diagnosis of lumbar strain and is greater than four months from time of injury. Given the fact that significant physical therapy has been utilized, she would fail to meet Official Disability Guidelines criteria for the role of twelve additional sessions.

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

Based on the clinical information provided, the request for physical therapy 2 x a week for 6 weeks is not recommended as medically necessary. The patient sustained a lumbar strain over 5 months ago and the patient has completed at least 8 sessions of physical therapy to date. The Official Disability Guidelines support up to 10 visits of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no specific, time-limited treatment goals provided. The patient's compliance with a structured home exercise program is not documented. Previous reviewer noted that the patient was discharged from physical therapy because all goals were met for range of motion and strength. Given the current clinical data, the requested physical therapy is not indicated as medically necessary.

### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

#### **1. *Official Disability Guidelines***

##### **References: ODG Low Back Chapter**

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. ([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](#)) In this RCT, exercise and stretching, regardless of whether it is achieved via yoga classes or conventional PT supervision, helps improve low back pain. ([Sherman, 2011](#)) 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](#)) In this RCT, two active interventions, multidisciplinary rehab (intensive, bio-psychosocial PT) and exercise (exercises targeted at trunk muscles together with stretching and relaxation), reduced the probability of sickness absence, and were more effective for pain than self-care advice at 12 months. ([Rantonen, 2012](#))

*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](#)) There is inconclusive evidence for the effectiveness of outpatient physical therapy after first lumbar discectomy. Although evidence from two trials suggested that intervention might reduce disability short-term, and more intensive intervention may be more beneficial than less intensive therapy, pooled results did not show statistically significant benefit. ([Rushton, 2011](#))

#### **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