AccuReview

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: May 4, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97110 Therapeutic Exercises and 97530 Therapeutic Activities 12 units (12 sessions of PT)

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

This physician is Board Certified in Occupational Medicine with over 34 years of experience.

REVIEW OUTCOME:

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

☒ 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:

02-02-12: ED Physician Note by FNP-C
02-02-12: CT Head, CT Cervical Spine, X-rays Cervical Spine interpreted by MD
02-07-12: Initial Medical Report by MD with Pain Management

02-07-12: Physician Record by DC with
02-07-12: X-rays Lumbar Spine interpreted by MD
02-07-12: Cervical X-ray interpreted by MD
02-09-12, 02-10-12, 02-11-12, 02-13-12, 02-14-12, 02-16-12: Rehab Progress Notes
02-16-12: Physician Record by MD with
02-16-12: Left Shoulder X-ray interpreted by MD
02-16-12: Lumbosacral X-ray interpreted by MD
02-21-12: Physician Record by PA-C with
03-06-12: Peer Review Report by DO
03-07-12: UR performed by DO
03-20-12: Physician Record by PA-C with
03-26-12: Preauthorization Request for 12 Sessions of Physical Therapy by MD with
04-05-12: Peer Review Report by MD
04-06-12: UR performed by MD
04-17-12: Physician Record by PA-C with

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx while unloading concrete out of the back of a mixer truck. The concrete chute loaded with concrete swung and struck him in the right side of his head. The chute also struck his right trapezius area and right cervical area and he pushed it off with his left shoulder. The claimant was seen in the ER then followed up by MD. The claimant has had conservative care including medication, activity modification and 6 sessions of physical therapy.

02-02-12: The claimant presented to the ER with complaints of blurred vision, neck pain, and nausea. His pain was rated an 8/10. On exam he was positive for neck pain and negative for hearing loss, ear pain, nosebleeds and ear discharge. He did have pain to the right ear only to external ear/auricle. He was positive for visual disturbance (blurred, momentary). He was positive for nausea, but negative for vomiting and abdominal pain. He was also positive for headaches but negative for dizziness and syncope. The claimant was tender per palpation of right ear auricle, no break in skin integrity; no ecchymosis or swelling noted. He had normal neck ROM and spinous process tenderness and muscular tenderness (right paraspinous) present. The claimant was sent for diagnostic testing. Diagnosis: Head contusion and cervical strain. The claimant was discharged with prescriptions for Cyclobenzaprine (Flexeril) 10 mg, Hydrocodone (Norco) 10-325 mg, and Ibuprofen (Motrin) 600 mg.

02-02-12: CT Head, Impression: Unremarkable noncontrasted CT scan of the brain. CT Cervical Spine, Impression: No fracture of the cervical spine. X-rays Cervical Spine, Impression: Negative views of the cervical spine.

02-07-12: The claimant was evaluated by MD for chief complaints of headache, neck pain and left shoulder pain. It was also reported that the claimant injured his upper back and lower back when he was struck by the chute because he twisted his thoracolumbar spine on impact with his neck area. On physical examination he was very tender in the

retroauricular area. He had decreased range of motion of the cervical spine and left shoulder. Diagnosis: 1. Concussion. 2. Cervical radiculitis. 3. Cervical sprain/strain. 4. Thoracic sprain/strain. 5. Lumbar sprain/strain. 6. Sprain and strain shoulder. 7. Cervicalgia. 8. Injury, head. Plan: Medication, Physical Therapy, and TENS unit. He was prescribed Duexis and Fioricet.

02-07-12: The claimant was evaluated by DC who recommended physical therapy.

02-07-12: X-rays Lumbar Spine, Impression: 1. Minor marginal spurring at the anterior superior margin of L4. 2. Slight right convex curvature of the lumbar spine which could be positional in origin. 3. Approximately 1 cm calcification overlying the right anterior pelvis, superimposed on the distal cecum, the possibility of an appendicolith cannot be excluded. 4. Otherwise negative.

02-07-12: Cervical X-ray, Impression: Normal cervical x-ray.

02-09-12, 02-10-12, 02-11-12, 02-13-12, 02-14-12, 02-16-12: Rehab Progress Notes. Physical Testing (ROM) was performed on 02/09/12 and 02/17/12. Cervical ROM went from 57% to 73% and Lumbar ROM went from 52% to 72%. On the 2/16/12 progress note it was indicated that the claimant reported his functional ability was increasing, his pain was rated a 5/10 and that his pain was unchanged. The therapist noted that the claimant was cooperative and tolerating treatment well, that his functional ability was improving and that his ROM and/or strength were improving.

02-16-12: Left Shoulder X-ray, Impression: Normal left shoulder.

02-16-12: Lumbosacral X-ray, Impression: The patient has large osteophyte superior anterior aspect of L4. Has slight narrowing of L5-S1 disc. Has slight scoliosis.

03-07-12: UR performed by DO. Reason for Denial: The claimant has had 6 prior sessions of PT without documentation of sustained functional improvement and should be progressed to an independent home exercise program focusing on stretching/strengthening and use of hot/cold packs for pain/spasms. There is no indication of a complication to recovery, co-morbidity, or extenuating clinical circumstance that would support continued physical therapy beyond the possibly exceeded guidelines. Therefore, continued physical therapy is not medically necessary.

03-20-12: The claimant was evaluated by PA-C who reported he continued to have neck, left shoulder and low back pain. Plan: Work Hardening if additional PT was denied and MRI of the left shoulder.

03-26-12: Preauthorization Request for 12 Sessions of Physical Therapy by MD with Dr. stated that the claimant has cervical radiculitis radiating down into his fourth and fifth fingers of his left hand. That he has dullness to pinprick sensation fourth and fifth fingers of left hand. ODG allows 12 sessions of therapy for cervical radiculitis. Since the patient has a very heavy duty job he needs more than 4 units per therapy sessions.

04-06-12: UR performed by MD. Reason for Denial: The claimant has had 12 prior sessions of PT, with no evidence of functional improvement. His work status is unknown. The bulk of the progress notes provided are duplicates and pertain to February 2012. Many of the reports are handwritten PT progress notes. There are no recent physician notes on file. There is no evidence that the claimant has responded favorably to the PT performed to date. The goals of further PT have not been clearly enunciated. Therefore, continued physical therapy is not medically necessary.

04-17-12: The claimant was evaluated by PA-C who placed on light duty and added Norco 7.5 mg to his regimen.

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

The previous adverse determinations have been partially overturned. The claimant has received 6 physical therapy sessions with documentation that his functional ability was improving and that his ROM and/or strength were improving. ODG Guidelines recommend 10 visits of PT for the diagnosis of a cervical sprain/strain and lumbar sprain/strain. Therefore, since the claimant has already received 6 sessions, I would only certify 97110 therapeutic exercise and 97530 therapeutic activities at no more than 4 units or 4 PT sessions, 60 minutes each session over one week. Noncertify 97110 therapeutic exercise and 97530 therapeutic activities, 8 units. ODG does not endorse more than 60 minutes per session due to muscle fatigue with prolong therapy sessions. This translates to 4 units per session or 60 minutes per session as each unit is 15 minutes long.

Per ODG:

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. (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. (Luijesterburg, 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

ODG Physical Therapy Guidelines –
Allow for fading of treatment frequency (from up to 3 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".
Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0):
9 visits over 8 weeks

Sprains and strains of neck ***(ICD9 847.0):***
10 visits over 8 weeks
Displacement of cervical intervertebral disc (ICD9 722.0):
Medical treatment: 10 visits over 8 weeks
Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment (discetomy/laminectomy): 16 visits over 8 weeks
Post-surgical treatment (fusion, after graft maturity): 24 visits over 16 weeks
Degeneration of cervical intervertebral disc (ICD9 722.4):
10-12 visits over 8 weeks
See 722.0 for post-surgical visits
Brachia neuritis or radiculitis NOS (ICD9 723.4):
12 visits over 10 weeks
See 722.0 for post-surgical visits
Post Laminectomy Syndrome (ICD9 722.8):
10 visits over 6 weeks
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

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)**