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April 9, 2018 Amended June 20, 2018

Description of the service or services in dispute:

12 Sessions (3 times a week for 4 weeks) of Post-Operative Physical Therapy for the Lumbar Spine

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified PM&R

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

- Overturned (Disagree)
- Upheld (Agree)
- Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX with a history of chronic low back pain for over XXXX. In XXXX, XXXX had an injury in XXXX where XXXX knee gave out and XXXX. XXXX had back pain since. XXXX subsequently had a lot of “back sprains” since then. On XXXX, XXXX was involved in a XXXX. XXXX used to work as a XXXX and stopped working in XXXX due to back pain.

Per a therapy re-evaluation note dated XXXX, the patient was evaluated by XXXX. XXXX had complaints of pain in the lower back, rated 4/10. XXXX was unable to work, secondary to dysfunction. The physical exam was notable for overall high pain and with decreased back movement. XXXX continued to demonstrate pain on the right with walking, movement and had trouble with balance and reliance on the rolling walker for community ambulation. The patient also had weakness in the right lower extremity. The diagnoses of spinal stenosis, lumbar region without neurogenic claudication; unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder; other intervertebral disc displacement of the lumbar region; low back pain; and generalized muscle weakness were established. XXXX stated the patient would benefit from further physical therapy two visits a week with an expected duration of five weeks.

Per a utilization review dated XXXX, the request for postoperative lumbar physical/aquatic therapy for 12 visits was denied as per the ODG Guidelines – Low back, Lumbar and Thoracic (Acute and Chronic) Physical Therapy (PT). Rationale: “The Official Disability Guidelines (ODG) recommends up to 16 postoperative physical therapy visits. The claimant has completed 11 visits to date with good progress noted. However, given that ODG does not recommend more than 16 postoperative visits, the request is not medically necessary. Therefore, the request for postoperative lumbar physical therapy for 12 visits is not medically necessary.” Regarding aquatic therapy, “Per ODG, aquatic therapy is recommended as an option form for exercise therapy, where available, as an alternative to land-based physical therapy. As the claimant is able to participate and is participating in land-based physical therapy, the request for

aquatic therapy is not medically necessary. Therefore, the request for postoperative lumbar aquatic therapy for 12 sessions is not medically necessary.”

Per a reconsideration review dated XXXX, XXXX upheld the denial for the postoperative lumbar physical/aquatic therapy for 12 visits with the following rationale. “Per ODG Guidelines recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. ODG guidelines support up to 16 physical/aquatic therapy visits status post laminectomy. In this case, the claimant has had at least 11 therapy visits. The additional request exceeds guidelines. In addition, it is not clear why the claimant cannot continue with home exercises in lieu of therapy. No exceptional circumstances are noted. It is also not clear that the claimant has had significant objective benefit from the recent therapy visits. Therefore, the medical necessity of the proposed treatment consisting of postoperative physical/aquatic therapy lumbar x12 has not been established and is not appropriate and is not medically necessary.”

Treatment to date included medications (XXXX with minimal relief and continued pain in legs, XXXX that decreased baseline pain by 50%), lumbar laminectomies x2 with left L5-S1 laminectomy in XXXX and XXXX, fusion at L2-L3 in XXXX, removal of hardware in XXXX, laminectomy discectomy at L4-L5 with discectomy on the right on XXXX, physical therapy (PT), spinal bone growth stimulator, hardware block, bilateral L2-L3 transforaminal epidural steroid (TESI) at L5-S1 with 90% relief for five hours then for two days, brace, revision laminectomy discectomy with partial right L4 and right L5 discectomy and excision of recurrent disc foraminotomy L4-L5 and L5-S1 on XXXX, pool therapy (poor experience) and postoperative physical therapy 12 visits authorized with 11 visits completed to date with good progress.

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 12 Sessions (3 times a week for 4 weeks) of Post-Operative Physical Therapy for the Lumbar Spine is not medically necessary. The patient is status post revision laminectomy discectomy with partial right L4 and right L5 discectomy and excision of recurrent disc foraminotomy L4-L5 and L5-S1 on XXXX and has been authorized for 12 postoperative physical therapy visits to date. Current evidence based guidelines support up to 16 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine
- AHRQ-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and Guidelines
- European Guidelines for Management of Chronic Low Back Pain
- Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment Guidelines

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.

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:

10 visits over 8 weeks

Sprains and strains of unspecified parts of back:

10 visits over 5 weeks

Sprains and strains of sacroiliac region:

Medical treatment: 10 visits over 8 weeks

Abnormality of gait:

8-48 visits over 8-16 weeks (based on specific condition)

Lumbago; Backache, unspecified:

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy:

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

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis:

10 visits over 8 weeks

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified:

10-12 visits over 8 weeks

Curvature of spine:

12 visits over 10 weeks

Fracture of vertebral column without spinal cord injury:

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury:

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Torticollis:

12 visits over 10 weeks

Other unspecified back disorders:

12 visits over 10 weeks

Work conditioning (See also Procedure Summary entry):

10 visits over 8 weeks

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) Compared with usual care, treatment of new LBP with early PT resulted in a statistically significant improvement in disability in a RCT with 220 participants. The PT involved only four sessions over 3 weeks, consisting of manipulation and exercise, among patients being seen for LBP in a primary care setting, and the effects persisted for one year. The authors suggest that the potential benefits of early physical therapy should be evaluated in light of the time and effort required to participate in physical therapy. (Fritz, 2015) See also specific physical therapy modalities, as well as Exercise; Work conditioning; Lumbar extension exercise equipment; McKenzie method; Stretching; Aquatic therapy; Group physical therapy. [Physical therapy is the treatment of a disease or injury using 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 instead of passive modalities 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)

Timing of PT initiation: Preliminary evidence suggests that early physical therapy may decrease cost without compromising outcomes. After initially screening 3855 articles, 14 studies were included in a systematic review. The majority of articles studied low back pain (only 2 articles studied cervical pain). For spinal pain, there was low-quality evidence that early versus delayed physical therapy was associated with decreased cost and decreased frequency of opioid prescriptions, advanced imaging, and surgeries. One subgroup analyzed showed improved function/disability with early physical therapy in an occupational health setting. These results suggest that it may be beneficial for physical therapist providers to be utilized early in an episode of care for a lumbar spinal disorder. (Ojha, 2016)

- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.