INDEPENDENT REVIEWERS OF TEXAS, INC.

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
6 physical therapy for the lumbar spine 3x a week for 2 weeks, as outpatient

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Internal Medicine

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

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XXXX whose date of injury is XXXX. On this date XXXX and injured low back, lower right side and anterior groin area. Diagnoses are listed as sprain of ligaments of lumbar spine and unilateral inguinal hernia without obstruction or gangrene. The patient has completed 20 physical therapy visits to date. Follow up note dated XXXX indicates that low back pain has not improved. Pain level is rated as 10/10. Patient states that overall the symptoms have increased. Pain increased. Range of motion decreased.

The initial request for six physical therapy for the lumbar spine three times per week for two weeks as outpatient was non-certified noting that the patient has attended 20 sessions of therapy to date. There was no complete set of physical therapy notes submitted by which plateauing and progress might be assessed. There are no objective indications of progressive, clinically significant improvement from prior therapy. Continuation of therapy should be predicated on a formal assessment validating improvement in function at intervals of six sessions. Official Disability Guidelines allow for up to 10 sessions of supervised therapy in this clinical scenario when there is evidence of functional improvement from initial therapy. After this, rehabilitation is expected to continue through a home exercise program. Given the unexplained findings, the requesting doctor is justified in looking further with additional diagnostic testing. However, at this point rehabilitation should continue via a home exercise program. The denial was upheld on appeal noting that the claimant has had physical therapy. Diagnostic studies including a CT myelogram have been essentially normal. Based on the reviews, the claimant continues to be symptomatic with significant complaints, and it does not appear that physical therapy has made much difference in XXXX condition. Physical therapy has not provided any significant benefit at this time. Therefore the request is not medically necessary.

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 six physical therapy for the lumbar spine

three times a week for two weeks as outpatient is not recommended as medically necessary, and the two prior denials are upheld. The submitted clinical records indicate that this patient has completed 20 physical therapy visits to date. Current evidence based guidelines support up to 10 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. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

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**
- **X 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

Official Disability Guidelines Treatment Index, 23nd edition online, 2018-Low Back Chapter updated 05/04/18
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.
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)

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 4-6 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) A systematic review yielded moderate- to low-quality evidence for effectiveness of postoperative exercise programs starting 4-6 weeks after lumbar disc surgery. Exercise programs seem to be more beneficial than no treatment, and high intensity exercises may be more effective than low intensity exercises. (Oosterhuis, 2013)

Post-surgical (fusion) rehab: Following lumbar spinal fusion, delayed start of rehabilitation results in better outcomes, and improvements in the group starting at 12 weeks were 4 times better than that in the 6-week group. (Oestergaard, 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)