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of the spine and extremities

GUEST COMMENTARY

The Recovery Audit Contractor Program: What Every (McKenzie) Physical Therapist Needs to Know!

Stephen M. Levine, PT, DPT, MSHA

Physical therapists should be aware that while at the same time there has been a significant increase in utilization of physical therapy services, governmental reports have been issued over the past several years highlighting the excessive payment for services that are not deemed medically necessary. According to published studies, fraud, waste, and mistakes amounted to approximately 8 cents for every dollar spent under the Medicare program. Unfortunately, over the past 6 years, these numbers have only continued to grow. Additionally, the Centers for Medicare and Medicaid Services (CMS) Comprehensive Error Rate Testing Program (CERT) identifies payment errors categorized into four primary areas: No Documentation, Insufficient Documentation, Medically Unnecessary Services, and Incorrect Coding. The most common service provided by physical therapists in outpatient settings and billed to the Medicare program under the Part B benefit is therapeutic exercise (CPT code 97110). The initial CERT data identified that over $100 million was improperly paid for therapeutic exercise alone in fiscal year 2004, due to either insufficient documentation or services that were not medically necessary as defined by the Medicare program. As part of a Corrective Action Plan to combat the startling error rates identified by the CERT program, CMS began the Recovery Audit Contractor (RAC) initiative in 2005. In order to understand the potential impact on physical therapist practice, it is important for physical therapists to understand some key points about the RAC Initiative.

Recovery Audit Contractors (RACs) are utilized to identify overpayments and underpayments and to recoup overpayments under Part A and Part B of the Medicare Program. As the states with the largest Medicare expenditure amounts, California, Florida, and New York were selected for a pilot program that started in 2005 and will last through May of 2008; however, the program has been so successful in recovering overpayments from health care providers, the Tax Relief and Health Care Act of 2006 expanded the demonstration project to the entire country, making it a permanent audit activity. As a result, the RAC program is being expanded rapidly and the following states will see RAC Audit Expansion by March of 2008: Arizona, Colorado, Maine, Massachusetts, Montana, New Hampshire, New Mexico, North Dakota, Rhode Island, South Dakota, Utah, and Wyoming. Nevada, Oklahoma, and Texas will see their RAC audits begin by October of 2008. The remainder of the states will see their RAC audits begin in January 2009 or later. Although all physicians, providers, and suppliers under the Medicare program are part of the Recover Audit Contractor Initiative, there are compelling reasons why physical therapists and physical therapy providers are prime targets for these audits: the amount of fraud and abuse as well as utilization of physical medicine and rehabilitation procedures has skyrocketed over the past 5 years. Unfortunately, physical therapists are often not aware that their coding and documentation practices may be their biggest exposure with regards to risk and/or liability in this area.

Increased attention on focused medical review, which is a component of almost any alternative payment system being discussed by legislators and provider groups on Capitol Hill, is causing Medicare contractors and private payers to increase the amount of resources dedicated to this area in the future. Not only are there risks that inadequate documentation may require any payments that a physical therapist or facility has previously received from Medicare or other insurance companies be refunded if documentation does not justify medical necessity, as defined by Medicare or other private payers, providers may unknowingly be committing fraud or abuse. The penalties for committing fraud or abuse are severe, and Medicare contractors are cracking down on issues of medical necessity as the new frontier in the attempt to reduce the amount of fraud, waste, and abuse in the Medicare program.

Although none of us went to physical therapy school because we enjoy documenting what we do, and too many of our profession have not taken the time to develop proficiency in this area, documentation is no longer a task that can be left to the last minute or performed quickly so that we can get to the next patient or get home at the end of the day. There is just too much at stake. Like clinical skills, documentation is a skill that must be learned and perfected, and is an essential component of physical therapist practice. Documentation is as critical to the justification of our profession as an essential component of the healthcare delivery system as are the clinical skills and expertise of the physical therapist who desires to be the autonomous practitioner of choice in the management of musculoskeletal dysfunction. If services are not adequately documented, there may be more at stake than simply a denial of payment or the requirement for providers to pay back money that has already been received. Survival in physical therapist practice in any setting, but particularly in the outpatient and private practice arenas, requires that we find efficient ways to document our care so that we can defend our interventions. But more importantly, regardless of the methodology we may choose to implement this component of practice, it is essential that we learn *what* must be included in our documentation in order to justify payment for physical therapy services in the outpatient setting and to minimize the risk of knowingly or unknowingly committing fraud or abuse. This is not only a matter of professional responsibility; it is a matter of survival!

This is a summary of the full article authored by Stephen M. Levine, PT, DPT, MSHA. For the full text of the article, visit: http://www.mckenziemdt.org/newsletter

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LIVE! FROM THE HILTON IN WALT DISNEY WORLD RESORT

Stephen M. Levine, PT, DPT, MSHA

JULY 25, 2008

Preconference Seminar of the
MDT Conference of the Americas

Reimbursement Issues in Outpatient Physical Therapy: Assuring Compliance & Avoiding Fraud & Abuse

http://www.mckenziemdt.org/conf2008-6.cfm

CASE STUDY

MDT Flexion/Rotation – A Group Effort

Jennifer Kornowski, MSPT, Cert. MDT

We hope you find the following case study to be informative. I liked it for 3 reasons: 1) The "McKenzie exercises" were not the "McKenzie Method" and Jennifer did a good job of recognizing this and reassessing. 2) It highlights the need for frequent reassessment and knowing what to expect (e.g. if he has reducible derangement, he should have been progressing at each visit. 3) It is an example of how Jennifer did a good job getting the patient on the right track and then using the MDT list serve to help her fine tune her methods when she ran into difficulty. – Audrey Long, PT, Dip.MDT, MICan Faculty

November 6:
Initial examination*
A 61 year old male truck driver for a lumber company sustained an injury to his back on July 16 at work while lifting and twisting the wrong way. He felt immediate pain in his left lower back. He continued to work over the next several days and his symptoms got progressively worse. The symptoms became severe with pain radiating down the back of the left leg into the calf. He was taken off work and underwent physical therapy where "McKenzie exercises" were done as well as core stabilization at another PT clinic. During the first visit, he stated that "PT was somewhat helpful while I was going, but the pain is pretty much the same as when I first injured it." I asked him what "McKenzie exercises" he was doing, and he described REIL as well as FIL. He also had some injections which provided temporary decrease of symptoms. Symptoms now are constant in the L LB and intermittent into L LE depending on activity. He was referred to me by an orthopedic spine specialist who only refers to McKenzie Cert. PTs.

November 7:
Patient reports decreased pain in L LE but increased into L PSIS. Rep SGIS L consistently decreases his pain in the thigh but increases/centralizes symptoms into the L PSIS. He reports symptoms currently 6/10 in L PSIS/buttock/upper thigh.

Reassessment: Trunk ROM major loss of flexion, moderate loss of extension, major loss of L side glide, moderate loss of R side glide. Rep SGIS Lx 10 NE on trunk ROM or symptoms; another x 10 NE. Retested REIL x 10 NE; another x 10 increase W with symptoms radiating further distal. REIL L shift x 5 increased W such that patient got up off the table and had to walk for several minutes before continuing. I next had him lie supine in hook lying x 10 RFIL NE on symptoms. Flex/Rot R (both hips to the left, shoulders to the right) 30 sec hold x 1 decrease B with symptoms centralizing into L PSIS and upper buttock. Another flex/rot R 30 sec x 2 B. Symptoms 3/10 into L PSIS with upper thigh symptoms abolished. Provisional classification confirmed with a change in directional preference. Patient instructed in flex/rot R 30 sec x 3 Q 2-3 hours.

November 8:
Patient reports he's doing somewhat better with decreased frequency of symptoms into the thigh and none into the calf. His symptoms are more localized into the L PSIS. He reports getting good relief of symptoms with flex/rot while in the clinic but had difficulty reproducing the same effect at home even with cushions on the floor. He continued to perform the Rep SGIS L because he felt that was more effective at relieving his symptoms since he had difficulty reproducing same "stretch" at home. Today he reports symptoms currently in the L PSIS 2/10.

Reassessment: Trunk ROM moderate loss of motion all directions. Rep SGIS L x 10 NE, another x 10 NE. Flex/Rot R 30 sec x 3 abolished all symptoms and increased trunk ROM all planes. Provisional classification and directional preference of flexion/rotation confirmed. Patient was again instructed in flexion/rotation with discussion of options such as the use of cushions for support at home.

November 9:
Patient discouraged as he is unable to get the same relief at home from the flexion/rotation stretch even using option of cushions for home. He has been performing Rep SGIS L instead because he feels he gets greater symptom relief. This visit he reports symptoms L PSIS 5/10.

Reassessment: Patient unable to maintain reduction with current principle of management. Recheck provisional classification to confirm directional preference. Trunk ROM moderate loss of motion all directions. Patient asked to perform flexion/rotation R 30 sec. x 3. He was unable to get relief. Therapist overpressure in flexion/rotation stretch R 30 sec. x 3 abolished all symptoms. He again expressed frustration at not be able to get same results at home. Again provisional classification confirmed. Principle of management confirmed with need for overpressure. Patient is unable to maintain reduction of symptoms without overpressure in the direction of flexion/rotation.

This case prompted me to post the MDT study group to see if my peers had any suggestions on how this patient could get the same results at home that he was getting in the clinic. Brian Mulhall discussed how he would progress this patient by describing a slightly different version of flexion/rotation along with holding the stretch longer. "We have the patients lie on the painful side, bottom leg straight, top leg at 90 degrees falling to table. Then instruct the patients to spin their shoulders to get their back as flat to the table as possible. We then instruct the patients to relax. After reading your description of the Flex/Rot you use - we have the patients hold for much longer than 30 seconds and do just one hold, not 3 repetitions of shorter holds. We have them hold it for at least 3 minutes and up to 5 minutes. Also if it works well for them, but doesn't last long we instruct them to let the leg drop off the bed or couch and reach back further with their arm to get a more exaggerated stretch."

November 12:
After reading Brian's post, I instructed the patient in that version of the stretch. The patient was able to abolish his symptoms independently at home after that session.

November 19:
Patient reports 90% improved. Mild complaints of central low back pain intermittent worse with sitting and driving. He is no longer experiencing symptoms into the L LE.

Reassessment: Trunk ROM minimal loss of flexion and extension. REIL x 20 abolished central LBP. Patient was instructed in REIL x 20 Q 2-3 hours and educated in lumbar roll for sitting and driving.

Discussion: In the past, my patients would have difficulty whenever flexion/rotation was their principle of management. We would struggle with how to recreate the same stretch at home. After posting this case to the MDT study group, the patient was able to go "further, further, further" which is what was necessary to maintain reduction. Prior to this case, my patients would take longer to reduce their symptoms because they couldn't produce enough overpressure on their own. This progression of forces produced dramatic results in a patient that was getting frustrated after several months of conservative management with little results. This case study is a good example of how to utilize the McKenzie Study group to help "fine tune" techniques that aren't quite getting the job done. I think this case also highlights that a certified MDT therapist truly practicing the MDT approach got different results than a therapist claiming to simply be providing "McKenzie exercises."

**For details of the examination findings, please refer to the full completed assessment form posted in this issue on our website via the MDT Resource Center.*

MDT Flexion/Rotation – A Group Effort

Brian Mulhall DC, CSCS, CCSP, Cert. MDT, Cert. ART, CKTP

"Fine tuning" each patient's reductive movement is one of the most rewarding, and sometimes most frustrating, aspects of utilizing the MDT approach. I'm amazed daily as to just how specific some reductive movements and their application have to be to obtain a lasting reduction.

Jennifer Kornowski posted on the McKenzie online study group a request asking if anyone had a way to prolong her patient's response to Flexion/Rotation of the lumbar spine. Flex/Rot is one of the movements that we use frequently with posteriolateral/lateral derangements in our office. Rob Vining, PT and I work together and Rob taught me the version of Flex/Rot we use today. I replied to her, generally describing our use of Flex/Rot and luckily it worked wonderfully for her patient.

Several days later, there was a question posted again on the McKenzie online study group, as to if/how we progress our patients back to sagittal after Flex/Rot.

Here was my response:

"Once the patient's lateral symptoms have resolved, centralized and remain better, we then attempt to progress to sagittal.

So, for instance if the patient is initially obstructed in RSG, Flex and Ext and has nerve tension in the right leg with a loss of muscle strength in the right iliopsoas and tibialis anterior, we do a mechanical evaluation and Flex/Rot is their reductive movement, where the patient lies on their symptomatic side (the right side) with the bottom leg straight, top leg in hook lying letting it drop to the table and then flattening their upper back to the table by rotating the shoulders to the left . They are sent home with a lumbar roll, precautions and home instructions to relax into the stretch and hold for 3-5 minutes at least 6 times throughout the day and as needed to abolish symptoms if they return.

They come back next visit with decreased symptoms overall. They are now obstructed in just Flex and Ext and there is no longer any loss of muscle strength in the right leg, but they have some continued mild nerve tension in the right leg.

We will then attempt to progress to sagittal with testing in REIL and see if afterward we elicit any return of the obstruction in RSG, loss of muscle strength or increased nerve tension in the right leg.

If the right lateral symptoms return, then the lateral aspect of the derangement is not fully reduced and we'll have them continue with Flex/Rot on the right side or press ups with hips to L maybe - whichever gives the best mechanical response.

If the lateral symptoms remain better and don't return and REIL produces a further mechanical improvement by restoring the losses in Flex and Ext and further decrease the nerve tension, they are sent home with REIL as their new exercise. The patient must also be educated with proper precautions on being aware of any return of the lateral symptoms and if they return to stop REIL and revert back to Flex/Rot on the right side as described earlier.

In our experience, it can take anywhere from 2 - 7 days to fully reduce the lateral symptoms with results that remain better and then progress them to sagittal. If their results with Flex/Rot are not lasting then Flex/Rot mobilizations are used to get them over the hump or even manipulation - as long as there is the proper mechanical improvement. Progression to sagittal is then utilized once the lateral symptoms are fully reduced and remain better."

The MDT approach protocols and basics are what we all want to adhere to as closely as possible, yet once progress has halted with a patient's recovery it is time to pursue different variables. There are so many different motions and variables possible using the MDT approach, the more we are able to share our experiences and clinical observations, the more options we will all have to obtain positive outcomes for our patients.

Additional tip

Audrey Long, PT, Dip.MDT, MICan Faculty

The lower leg extended, as described in this case study, is often very effective. However, as always with MDT, it is never a recipe. The amount of flexion of the hips/knees will vary a bit in every patient. Sustain one position, if centralization starts, stay there for 3-5 minutes. If there is no centralization or the progress plateaus, then "explore" and test different angles with the legs. The patient can do these "tests" themselves, after adequate explanation, if you have to leave them for a few minutes. The "right' combination can be anything from both hips very flexed well above 90 degrees to both almost straight, or one straight and one flexed. Last year, I treated a bus driver who went home and discovered on his own that the TOP hip extended beyond neutral and the bottom (symptomatic) flexed worked best. I would never have thought of that!! This is rare and the opposite of what is described above, but is an example of the power of tracking that distal symptom and empowering the patient.

Watch for our new "Guide to Abbreviations" to be posted in the MDT Resource Center

Clinical Reasoning Exercise re: Case Study

Audrey Long, PT, Dip.MDT, MICan Faculty

Can you score 10/10 points? Question #9 is worth 2 points. Find the answers online at: http://www.mckenziemdt.org/newsletter.cfm

1. In Jennifer's case study, what is the first clue that this patient might have a relevant lateral component? It's in the FIRST sentence.
2. When you read that he was doing both flexion and extension exercises, what do you ask yourself?
3. In the Nov 6th entry, what is the biggest clue that he likely has a reducible lesion and should have been progressing well if MDT had been applied correctly?
4. In the observation and ROM section, what confirms that a relevant lateral component is highly likely?
5. Using all the above information (history, standing posture, ROM) would it have been possible to save some time with testing on day 1 and on the follow-up visits?
6. On the assessment form and return visits, the effect of SGIS was "NE". Does this sound "odd" to you? List at least three questions that come to mind when you read this? These questions would help guide you with "what to do next":
   a)
   b)
   c)
7. How would you tidy up the recording (terminology) on the repeated movements of the assessment form?
8. What variations to the side glide might have been helpful?
9. BONUS question. What information is mentioned in the case study in a vague way? It is an item that if tested and reported in detail would be a key tool in the decision to return to sagittal testing or stay with lateral progression. This little tip can save you lots of time in the clinic.

Three Fundamentals of Practice Building
Don't Spend Another Dime On Marketing Until You Memorize Them…

By David C Steinberg and Trent A Wehrhahn, Principals, PTreferralMachine.com © 2007

If you're like most professionals, from time to time you wonder about what it takes to build a successful practice. You see and feel the competitive challenges, and it's easy to get discouraged and draw the conclusion that you may be missing something. Like most disciplines, business development takes hard work and patience – it's a talent that comes to all of us only after studying and applying sound fundamentals. Today's *Business Corner* outlines three fundamental principles to help focus your effort.

Before getting into the three fundamentals, let's talk attitude: Are you willing to do whatever it takes to get better at business development, or is your philosophy simply to take whatever comes your way based on the sheer momentum of the marketplace? Taking whatever comes your way based on marketplace momentum means you sit back and wait to be served your share of the pie. Committing yourself to getting better at business development, on the other hand, means you help bake the pie, and then, warm out of the oven, you cut yourself a generous slice *before the rest of the pie is even served.* If you want to be there for the baking and the taking, the three fundamentals may be an important part of your recipe.

1. <u>You Must Distinguish Your Practice From Your Competitors:</u> To grow your business, the challenge is always making your audience want to listen to you in the first place. Without experience working directly with you, your target audience is generally skeptical, hates making decisions, and resists change at almost any cost. Yes, I'm talking about your future patients and referral sources. To overcome this, you need to expose your marketplace to enough quantity and quality of information that positions you as an expert – this is <u>not</u> the same thing as demonstrating competency. Being competent is nothing special. Being an expert makes you sought after to bring a *specific result*. As a certified McKenzie practitioner, this means communicating in a commanding way the unique advantages of the MDT method <u>and</u> what it takes to deliver *expected results*. You must be able to **communicate** these key advantages in a compelling way to people who probably don't want to take the time to meet with you *until they understand the potential benefits of your expertise.* Think about it from their standpoint, why should they invest their valuable time just for the privilege of an introduction? Trying to meet with potential referral sources and prospective patients before they have reviewed enough introductory information to determine their basic level of interest is a common mistake. Making this mistake trains your audience to *lock the door,* not open it. That's why salespeople burn out – with each premature poorly thought out contact, they wear out each opportunity. Good marketing materials **communicate** *systematically* to educate your target audience on how to make the connection between your unique expertise and the expected results they value.
2. <u>You Must Condition Your Audience To Consult With You First In Your Area Of Expertise:</u> Referral sources and prospective patients are a lot more sophisticated than they used to be. They have access to more information than ever. Think about your own health care decisions. Do you use one office for anything and everything? I don't. My family has a pediatrician for the kids, Urgent Care for non emergent "emergencies," an OB GYN, two internists, and more get added to the list with each new problem! So why don't I call just one provider for all my needs? The answer is simple: Not even the biggest local hospital has enough resources to help me get the answers I'm seeking on a consistent basis. None of them have contacted me about the merits of contacting them on something like back pain. The good news is that you can fill these voids. The first one to do this in their marketplace on a consistent basis wins.
3. <u>You Must Systematize Your Message:</u> There are two main advantages of systematizing your message: First, you determine what kinds of information help your audience understand the most important and relevant issues they need to consider for typical questions ahead of time instead of 'winging it.' And second, your weakest communication links will become stronger because the system compensates for their weaknesses with preformatted information. To appreciate the value of this, think about how the typical receptionist is trained to answer even the most basic question that doesn't relate to an appointment schedule or payment status – if your answer is, "I'll have someone call you back," then chances are your message isn't systematized. Chances are you could provide enough information to facilitate the next step in your educational process for most questions without having to handle each question as special call back. For example, "Can you tell me how McKenzie works?" Would your audience view your expertise in a more favorable light if you said, "Sure. Would you like to review introductory information at your leisure on our website, or should I put in the mail? If you'd like, I can review that with you now while you're on the phone. It should only take three minutes…"

In conclusion, the three fundamentals of practice building are about creating the kind of service where you effectively communicate with your target market at all points of contact. When you begin to follow this blueprint, you'll compete more effectively and begin winning more of the visits you deserve.

Still seeking the right fit for marketing support? We invite you to our FREE webinar to learn more.
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From MDT Bulletin, Vol. 2, No. 1
Clinical Reasoning Exercise re: Case Study
Did you score 10/10 points? (Remember, question #9 is worth 2 points.)

1. In Jennifer's case study, what is the first clue that this patient might have a relevant lateral component? It's in the FIRST sentence.

   When the patient distinctly describes a twist, it is not uncommon to find a relevant lateral component. If a lateral force (twist) contributed to the problem it makes sense that a lateral force might be needed to resolve it.

2. When you read that he was doing both flexion and extension exercises, what do you ask yourself?

   Was he taught his "McKenzie exercises" at random, or after an MDT assessment? Was he doing both because he was ready: in the recovery of function phase or does it sound too early for both? Should he have only been doing one direction only and was he "undoing" the good of his directional preference by doing movements the opposite way as well?

3. In the Nov. 6th entry, what is the biggest clue that he likely has a reducible lesion and should have been progressing well if MDT had been applied correctly?

   His lower extremity symptoms were intermittent and depended on the activity (i.e. mechanical forces). If his leg pain comes on and off with activity, the MDT approach will very likely be able to deduce the likely derangement by prescribing a therapeutic movement and educate the patient to avoid the provocative activities.

4. In the observation and ROM section, what confirms that a relevant lateral component is highly likely?

   Although his shift is slight, it is relevant because there is pain and asymmetrical ROM with SG testing. Also, his pain increased (but not in the leg which would have been even more telling) with postural correction showing a poor initial response to extension.

5. Using all the above information (history, standing posture, ROM), would it have been possible to save some time with testing on day 1 and on the follow-up visits?

   With the twisting mechanism of injury, his strongly unilateral symptoms, slight but relevant lateral shift, the therapist can use clinical reasoning to start testing with lateral techniques (side glides and/or testing rotation). Note: if the patient was also worse with standing and walking then definitely I would have started testing with side glides. At each visit, certainly one FIS and EIS should be tested for ROM baselines, but if the side glides are still restricted, the lateral component is not reduced enough to start extension so the result of repeating tests in the sagittal plane could have been anticipated (the patient peripheralized). Staying focused on lateral techniques may have saved time.

6. On the assessment form and return visits, the effect of SGIS was "NE". Does this sound "odd" to you? List at least three questions that come to mind when you read this? These questions would help guide you with "what to do next":

   a. ***This patient had reasonably high pain ratings. Could he really do the movements with NE which is recorded twice on the form?***
   b. ***He also had a moderate to major losses of range of movement. Could he really do the movements with NE which is recorded twice on the form?***
   c. ***His calf pain abolished, did it remain better (as in centralizing) or was it no better?***

7. How would you tidy up the recording (terminology) on the repeated movements of the assessment form?

   Considering the thoughts from #6 above, I suspect that this patient hurt when he moved. If not, then he was not being pushed to his available end range (but the ROM chart says ERP so I think he was taken far enough). Therefore, I strongly suspect that what really happened was "increase, not worse" in those places where we see NE. e.g., Left SGIS – was the third set really NE or did she mean increase not worse or decrease not better? Also, "Abolish calf" is written in the wrong column. Abolish is a "during word." We need to know if this effect was lasting e.g., did it "remain better" and/or was "centralizing" or was it "abolish calf, no better"?

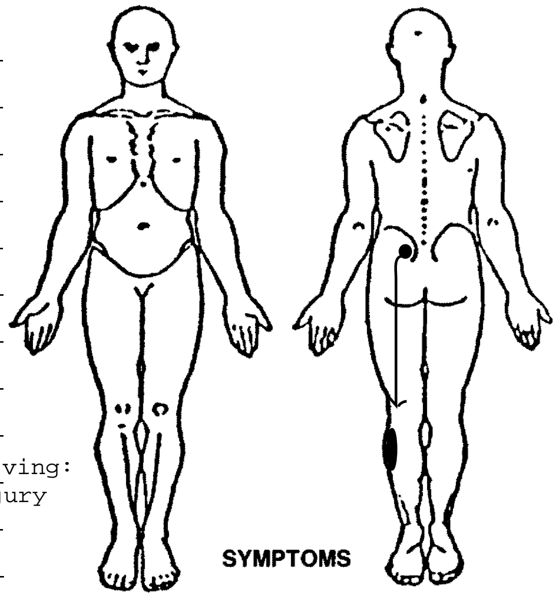
8. What variations to the side glide might have been helpful?

   The therapist could have tried therapist overpressure e.g., the manual shift correction to help the patient go further, further, further) or the patient could have been asked to either slightly bend his knees and or posterior pelvic tilt while doing the side glides. Perhaps this little bit of flexion "opens" the space a bit so that full side glide can be achieved (and pain reduced or centralized). Then the patient "progresses" by doing the side glides in less and less flexion over the next few days until they can do them in neutral with good effect.

9. BONUS question. What information is mentioned in the case study in a vague way? It is an item that if tested and reported in detail would be a key tool in the decision to return to sagittal testing or stay with lateral progression. This little tip can save you lots of time in the clinic.

   At each reassessment, the patient continues to have restricted and asymmetrical ROM. While this was nicely tested and recorded, the therapist could have thought to herself, "The lateral component is not fully reduced. Likely, testing extension will still cause peripheralization like it did on day one, so I will continue with side glides or rotation until the obstructed ROM of side glide is cleared."

THE McKENZIE INSTITUTE LUMBAR SPINE ASSESSMENT



Date: 11/06/07

Name: R.S. Sex **M** / F

Address:

Telephone:

Date of Birth: Age 61

Referral: *GP / Orth / Self / Other*

Work: Mechanical Stresses: Driver for lumber company

Leisure: Mechanical Stresses:

Functional Disability from present episode: Bending, lifting, driving: off since week of injury

Functional Disability score:

VAS Score (0-10): 7-8/10

HISTORY

Present Symptoms: (L) PSIS → post thigh → lateral calf

Present since: 7/16/07 *Improving / **Unchanging** / Worsening*

Commenced as a result of: lifting & twisting heavy piece of wood *Or no apparent reason*

Symptoms at onset: ***back*** */ thigh / leg* left PSIS → into (L) post thigh & calf

Constant symptoms: ***back*** */* ***thigh*** */ leg* Intermittent symptoms: *back / thigh /* ***leg***

Worse: ***bending*** ***Sitting*** / ***rising*** *standing* *walking* *lying*

am */ as the day progresses / pm* ***when still*** */ on the move*

other driving > 1 hour

Better: *bending* *sitting* *standing* ***walking*** *lying*

am / as the day progresses / pm *when still /* ***on the move***

other

Disturbed Sleep: ***Yes*** */ No* Sleeping postures: *prone / sup / side R / L* Surface: *firm / soft / sag*

Previous Episodes: 0 **1-5** 6-10 11+ Year of first episode:

Previous History: general low back aches resolve in a few days

Previous Treatments: Ø

SPECIFIC QUESTIONS

Cough */ ~~Sneeze~~ /* ***Strain*** */* ***+ve*** */ -ve* Bladder: ***normal*** */ abnormal* Gait: ***normal*** */ abnormal*

Medications: *Nil / NSAIDS / Analg / Steroids / Anticoag / Other* Tylenol 3, Motrin, Prilosec, Lipitor

General Health: ***Good*** */ Fair / Poor*

Imaging: ***Yes*** */ No* MRI, bone scan, EMG - ; Results: bulging disc x 2 ?

Recent or major surgery: *Yes /* ***No*** Night Pain: *Yes /* ***No***

Accidents: *Yes /* ***No*** Unexplained weight loss: *Yes /* ***No***

Other:

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EXAMINATION

POSTURE

Sitting: *Good* / ***Fair*** / *Poor*   Standing: *Good* / ***Fair*** / *Poor*   Lordosis: ***Red*** / *Acc* / *Normal*   Lateral Shift: ***Right*** (slight) / *Left* / *Nil*

Correction of Posture: *Better* / ***Worse*** / *No effect*   W in low back, NE on LE   Relevant: *Yes* / *No*

Other Observations:

NEUROLOGICAL

Motor Deficit   Reflexes

Sensory Deficit   Dural Signs

MOVEMENT LOSS

	Maj	Mod	Min	Nil	Pain
Flexion				X	
Extension	X				PDM
Side Gliding R		X			ERP
Side Gliding L	X				ERP

TEST MOVEMENTS

Describe effect on present pain – During: produces, abolishes, increases, decreases, no effect, centralising, peripheralising. **After:** better, worse, no better, no worse, no effect, centralised, peripheralised.

	Symptoms During Testing	Symptoms After Testing	Mechanical Response ↑Rom	Mechanical Response ↓Rom	Mechanical Response No Effect
Pretest symptoms standing:	(L) PSIS 7/10 → (L) post thigh				
FIS					
Rep FIS					
EIS					
Rep EIS	x8 periph → (L) lat calf	W			X
Pretest symptoms lying:	5/10 (L) PSIS → mid post thigh				
FIL					
Rep FIL					
EIL					
Rep EIL	x10 NE; x10 c̄ (L) shift NE x10 NE				
If required pretest symptoms:					
SGIS – R					
Rep SGIS - R					
SGIS - L					
Rep SGIS- L	x10↓ B x10↓ B x10 NE	Abolish (L) calf	X		

STATIC TESTS

Sitting slouched   Sitting erect

Standing slouched   Standing erect

Lying prone in extension   Long sitting

OTHER TESTS

PROVISIONAL CLASSIFICATION

Derangement   Dysfunction   Posture   Other

Derangement: Pain location   Asymmetrical below knee

PRINCIPLE OF MANAGEMENT

Education   X   Equipment Provided   L-Roll

Mechanical Therapy: ***Yes*** / *No*

Extension Principle: Lateral Principle: 20x RSGIS L

Flexion Principle: Other: Every 2-3hrs unless periph of SX into calf

Treatment Goals: Reassess 24hrs

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