

Case Number:	CM14-0199250		
Date Assigned:	12/09/2014	Date of Injury:	07/31/2014
Decision Date:	01/23/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/26/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker's original date of injury was July 31, 2014. The primary industrial diagnosis is lumbar sprain and strain. Other industrial diagnoses include right carpal tunnel syndrome, right trigger finger, and right elbow pain. The patient continues on Flexeril, Motrin, and Mentherm topical for pain management. The disputed issue is a request for an additional three sessions of physical therapy for the lumbar spine. The notes indicate that 3 disputed sessions of PT have already been carried out and therefore this is a retrospective request. A utilization review determination on October 30, 2014 had denied these additional three sessions of physical therapy. The rationale for this denial was that the ACOEM guidelines allow for one or two visits of physical therapy for education, counseling, and evaluation of a home exercise program. The injured worker had participated in five sessions of physical therapy prior to these additional three visits, and therefore the reviewer felt that the additional sessions were not necessary.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Additional Physical Therapy X 3, Lumbar Spine, DOS: 08/22/14, 08/26/14, 08/29/14:
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 98-99.

Decision rationale: Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with 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. Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. Occupational Medicine Practice Guidelines, Low Back Chapter, page 298. Comfort is often a patient's first concern. Nonprescription analgesics will provide sufficient pain relief for most patients with acute and sub-acute symptoms. If treatment response is inadequate (i.e., if symptoms and activity limitations continue), prescribed pharmaceuticals or physical methods can be added. Comorbid conditions, side effects, cost, and provider and patient preferences guide the clinician's choice of recommendations. Table 12-5 summarizes comfort options. Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy indicates 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. 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. 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. Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. One clinical trial found both effective, but

chiropractic was slightly more favorable for acute back pain and physical therapy for chronic cases. 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. Better symptom relief is achieved with directional preference exercise. 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. In this RCT, exercise and stretching, regardless of whether it is achieved via yoga classes or conventional PT supervision helps improve low back pain. 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. 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. The most commonly used active treatment modality is Therapeutic exercises, but other active therapies may be recommended as well, including neuromuscular reeducation, Manual therapy, and Therapeutic activities/exercises . A recent RCT comparing active spinal stabilization exercises 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. In this RCT, two active interventions, multidisciplinary rehab (intensive, biopsychosocial 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. 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. Without proper patient selection, routine physical therapy may be no more effective than one session of assessment and advice from a physical therapist. 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. 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. 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/sub-acute 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. 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. 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. 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. 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. 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. 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. In the case of this injured worker, there is documentation of five sessions of physical therapy for the lumbar spine prior to the additional request of three sessions of physical therapy. Since the CPMTG only addresses myalgia, CRPS, and neuritis in terms of duration of therapy, the ODG are referenced above and have more specific guidelines regarding the time course of various lumbar pathologies. For lumbar sprains and strains, a total of 10 sessions of physical therapy is a general recommendation. Since the patient has only had five sessions of physical therapy prior to the three additional sessions that are being disputed, this request is medically appropriate. The patient continues with dysfunction and has work restrictions. A full initial course of physical therapy should be offered to this worker. Therefore the request is medically necessary.