MAXIMUS Federal Services

Case Number:	CM15-0030086		
Date Assigned:	02/23/2015	Date of Injury:	09/24/2014
Decision Date:	04/14/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/18/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: District of Columbia, Virginia
Certification(s)/Specialty: Internal Medicine

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 is a 43 year old, female patient, who sustained an industrial injury on 09/24/2014. A primary treating office visit dated 12/02/2014 reported the patient with subjective complaint of neck and thoracic back pain. She did attend 1 session of therapy. Objective findings showed the patient with mild tenderness to palpation in the thoracic region on the paraspinal muscles. She continues to have tenderness to palpation of the lumbar paraspinal muscles. Her active range of motion revealed forward flexion, extension and lateral flexion right all at 20 degrees and the lateral flexion left at 30 degrees. A request was made for 6 additional physical therapy sessions with iontophoresis for thoracic/lumbar spine. Radiography review showed thoracic spine with mild scoliosis and mild endplate degenerative changes. The following diagnoses are applied; lumbosacral strain, lumbar strain persistent, thoracic strain persistent pain, right sciatica with pain radiating to the right buttock and scoliosis, idiopathic, nonindustrial. On 01/28/2015, Utilization Review, non-certified the request, noting the CA MTUS, Chapter 12 Low Back Complaints, ACOEM, physical Manipulation was cited. On 02/18/2015, the injured worker submitted an application for independent medical review of requested services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy x 6 with iontophoresis for thoracic and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 98-99.

Decision rationale: Per MTUS: Physical Medicine: Recommended as indicated below. 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. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26MTUS (Effective July 18, 2009) Page 99 of 127swelling, 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. (Fritz, 2007)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. Per review of clinical data provided, the patient had improvement of her symptoms following physical therapy for lumbar strain. The patient had only had 1 PT session. Additional PT sessions, would exceed guidelines and would not be indicated at this time.

Chiropractic x6 visits for thoracic and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 58-60.

Decision rationale: Per MTUS: Manual therapy & manipulation: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care: Not medically necessary. Recurrences/flare-ups: Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines; a. Time to produce effect: 4 to 6 treatments. b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. (Colorado, 2006) Injured workers with complicating factors may need more treatment, if documented by the treating physician. Number of Visits: Several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Active Treatment versus Passive Modalities: Manipulation is a passive treatment, but many chiropractors also perform active treatments, and these recommendations are covered under Physical therapy (PT), as well as Education and Exercise. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz,2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. Current Research: A recent comprehensive meta-analysis of all clinical trials of manipulation for low back conditions has concluded that there was good evidence for its use in chronic low back pain, while the evidence for use in radiculopathy was not as strong, but still positive. (Lawrence,2008) A Delphi consensus study based on this meta-analysis has made some recommendations regarding chiropractic treatment frequency and duration for low back conditions. They recommend an initial trial of 6-12 visits over a 2-4 week period, and, at the midway point as well as at the end of the trial, there should be a formal assessment whether the treatment is continuing to produce

satisfactory clinical gains. If t he criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow-up course of treatment may be indicated consisting of another 4-12 visits over a 2-4 week period. According to the study, "One of the goals of any treatment plan should be to reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent strengthening and range of motion exercises, and rehabilitative exercises. Patients also need to be encouraged to return to usual activity levels despite residual pain, as well as to avoid catastrophizing and over-dependence on physicians, including doctors of chiropractic." (Globe, 2008) These recommendations are consistent with the recommendations in ODG, which suggest a trial of 6visits, and then 12 more visits (for a total of 18) based on the results of the trial, except that the Delphi recommendations in effect incorporate two trials, with a total of up to 12 trial visits with are-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24). Payors may want to consider this option for patients showing continuing improvement, based on documentation at two points during the course of therapy, allowing 24 visits in total, especially if the documentation of improvement has shown that the patient has achieved or maintained RTW. Per review of the clinical data provided, the request for chiropractic manipulation therapy is outside of the time frame of the initial thirty days of symptoms. This would not be indicated.