

<b>Case Number:</b>	CM15-0053101		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	06/13/2002
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 36 year old male, who sustained an industrial injury on 06/13/2002. Diagnosis included spinal cord injury paraplegia C8 incomplete. Documentation submitted for review included physical therapy progress notes. According to an outpatient team evaluation dated 01/19/2015, the injured worker's goals were to improve strength and standing so he could walk with his braces. According to a partially legible progress report dated 02/16/2015, the injured worker reported that he was very sore after his last treatment. Assessment included instruction in the use of adaptive fitness equipment for upper body strength in preparation for gait with bilateral KAFO's (knee-ankle-foot orthosis). The injured worker did not bring KAFO's in. Intervention was noted as moderate assist set up, instructed on set up and needs further instruction. Currently under review is the request for additional physical therapy on the bilateral lower extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy (2 x 8) on the bilateral lower extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 114. Decision based on Non-MTUS Citation Official Disability Guidelines Physical Therapy Guidelines (Lumbar).

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 98-99 state the following: "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 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. (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." In the case of this injured worker, the submitted documentation indicate that the patient has an incomplete spinal cord injury (which the CA MTUS and ODG do not directly specify a specific time course). The injury date was remote, but a recent evaluation by physical therapy has taken place at a specialized rehabilitation center. The reported reason for 16 visits of PT are to work on balance and improve the patient's ambulation with assistive devices. There is indication that the patient has impaired balance, which is a demonstrated need. Although the patient has had PT in the past, spinal cord injury presents a unique circumstance in which there may be a long-term need for PT. However, guidelines require documentation of functional improvement, which should take place at shorter intervals than every 16 sessions of PT. The patient should have a shorter course, and with documentation of progress, future sessions may be indicated. The IMR process cannot modify original requests, and therefore the original requested 16 PT sessions is not medically necessary.