

<b>Case Number:</b>	CM13-0055047		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	11/30/2009
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	10/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/20/2013

### 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 49 year old male with an industrial injury dated 11/30/2009 while serving a search warrant. His diagnoses include spinal stenosis and cervical spinal stenosis. Recent diagnostic testing has included x-rays of the cervical spine (no date) showing some facet joint changes and mild to moderate foraminal narrowing, and x-rays of the lumbar spine (no date) showing some rotation of the spinous process between L4 and L5, loss of interpedicular distance on the left at the L5-S1, and loss of disc height. Previous treatments have included conservative care and medications. In a progress note dated 10/10/2013, the treating physician reports neck and low back pain with stiffness and tightness, decreased range of motion, and low back pain that radiates to the right buttock and sometimes the right leg. The objective examination revealed slight increase of pain with range of motion in the low back, increased pain with extension of the neck and side to side turning, and decreased sensation in the left hand and fingers. The treating physician is requesting 12 physical therapy sessions for the cervical and lumbar spines which was modified by the utilization review. On 10/22/2013, Utilization Review modified a request for 12 physical therapy sessions for the cervical and lumbar spines to the approval of 6 physical therapy sessions for the cervical and lumbar spine, noting that a short course of treatment is recommended to address the increased symptoms and return the injured worker to a self-managed home exercise program is reasonable. The MTUS and ODG Guidelines were cited. On 11/20/2013, the injured worker submitted an application for IMR for review of 12 physical therapy sessions for the cervical and lumbar spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **TWELVE (12) PHYSICAL THERAPY SESSIONS FOR THE CERVICAL / LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792  
Page(s): 98-99, 59-60.

**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 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." 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 the 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 6 visits, 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 a re-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. Based on MTUS recommendations, 6 initial PT sessions would be appropriate. Then the patient should then have a reassessment before continuing on with PT. 12 sessions would not be recommended at the initial outset.