



<b>National Imaging Associates, Inc.</b>	
<b>Clinical guidelines</b> <b>PASSIVE TREATMENT</b>	<b>Original Date:</b> November 2, 2015 <b>Page 1 of 14</b>
<b>Physical Medicine – Clinical Decision Making</b>	<b>Last Review Date:</b> June 2017
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### **Policy Statement**

This organization does not support the use of multiple passive treatments for the care of musculoskeletal pain within the scope of network practitioners. Most passive treatments have similar physiological effects related to pain control and reduction of inflammation. The use of modalities with duplicative physiological effects is unnecessary and inappropriate. Multiple passive treatments have not been shown to improve or accelerate patient health outcomes.

Initial Clinical Reviewers (ICRs) and Physician Clinical Reviewers (PCRs) must be able to apply criteria based on individual needs and based on an assessment of the local delivery system.

### **Purpose**

This policy will be used to provide medical necessity guidelines to support passive treatment services for musculoskeletal conditions in a clinical setting.

### **Scope**

Physical medicine participating network practitioners, including rendering chiropractors, physical therapists, occupational therapists, speech therapists and therapist assistants as applicable. This policy also applies to out of network practitioners as dictated by the health plan.

### **Definition**

#### Modality

Modality is defined as any group of agents that may include thermal, acoustic, radiant, mechanical, or electrical energy to produce physiologic changes in tissues of therapeutic purposes. Modalities affect tissue at the cellular level.

#### Multiple Passive Modalities

Multiple passive modalities are defined as the use of and/or billing of two or more physical medicine modalities each visit or during the same session to the same region.

#### Passive Modalities

Modality that is applied by the provider or in a clinical setting and does not involve active participation by the patient. The purpose of passive modalities use is to promote pain reduction, improve function, and quickly transition the patient to self-care engagement.

## Procedure

Procedure is a service provided to increase the functional abilities in self-care, mobility, or safety.

- I. The following is a list of procedures and modalities considered to be passive treatment:
  - A. Thermal and light therapy – Hot/cold (97010), diathermy (97024), microwave (97020) infrared (97026), ultraviolet (97028), ultrasound (US) (97035), paraffin bath (97018), and whirlpool (97022).
  - B. Electrical therapy – High volt, low volt, interferential current, transcutaneous electrical nerve stimulation (TENS) (97014 and 97032).
  - C. Mechanical – mechanically assisted and often a sustained pull of the spine or limb such as traction (97012). The use of traction for low back pain (LBP), with or without sciatica, is not supported by the literature, and is therefore not considered medically necessary.
  - D. Therapeutic massage and manual therapy (97124 and 97140). Manual therapy includes Active Release Technique, trigger point therapy, myofascial release, mobilization/manipulation, manual lymphatic drainage, and manual traction.

## II. Appropriate use of passive treatment

Passive treatment modalities may be utilized in the initial acute stage of a condition for pain control, reduction of inflammation, or reduction of muscle spasm. As a condition progresses, passive care should be replaced by active treatment modalities such as therapeutic exercise. Insufficient evidence exists to support the continued use of passive treatment as a means for improved clinical outcomes.

Passive modalities are considered to be clinically appropriate and/or necessary in the conservative management of neuromusculoskeletal conditions when:

- There are no contraindications to the intervention
- Self-administration is implausible or places the patient at risk of harm
- Used primarily during the initial period of an episode of treatment
- Used to support an active care approach (i.e., therapeutic exercise)
- Used for a particular condition for which there is an evidence-basis of significant benefit

Passive modalities are considered NOT to be clinically appropriate and/or necessary when:

- Patient safety is jeopardized by the application of the modality
- The modality can be safely self-administered
- Used during a course of treatment, which continues beyond the initial period
- Used as the primary or sole therapy
- Greater than one passive modality is used involving the same body region(s)
- Used largely for the comfort and convenience of the patient
- Used as part of the routine office protocol

### III. Exclusions

The use of chiropractic manipulation (98940-98943) is not considered a duplication of service or physiological effect when used in conjunction with passive treatment modalities, except for the following:

The National Correct Coding Initiative (NCCI) edits require that the manual therapy techniques be performed in a separate anatomic site than the chiropractic adjustments in order to be reimbursed separately.

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### Additional Information

The preponderance of evidence appears to support either a lack of efficacy or insufficient data to make a judgment on benefit for the modalities evaluated. When a positive outcome was described, the reported treatment effects were modest. Similarly, the duration of treatment effectiveness was typically reported as short (2 weeks to 2 months). Most international guidelines recommend these interventions should only be used reservedly based upon individual circumstances, and not as a principle component of a treatment regime.

The use of passive modalities in the treatment of neuromusculoskeletal conditions presents the inherent risk of promoting passive dependence. It is the responsibility of the treating practitioner to judiciously apply passive modalities and encourage active patient participation in the treatment plan. Passive treatment is generally viewed as appropriate when used for a short period of time and in conjunction with an active care.

Surface electrical muscle stimulators (direct or alternating current, not high-voltage galvanic current) are considered experimental and investigational for the management of idiopathic scoliosis because there is inadequate evidence of its effectiveness and safety in the peer-reviewed published medical literature.

Resistive exercises, spinal manipulation, whole body vibration, manual therapy, and the Clear Protocol are considered experimental and investigational for the treatment of scoliosis because their effectiveness for this indication has not been established.

A review on non-pharmacological therapies for acute and chronic LBP by the American Pain Society and the American College of Physicians concluded that therapies with good evidence of moderate efficacy for chronic or sub-acute LBP are cognitive-behavioral therapy, exercise, spinal manipulation, and inter-disciplinary rehabilitation (Chou, 2007). For acute LBP, the only therapy with good evidence of efficacy is superficial heat.

No high quality evidence was found to support the use of ultrasound for improving pain or quality of life in patients with non-specific chronic LBP. There is some evidence that therapeutic ultrasound has a small effect on improving low-back function in the short term, but this benefit is unlikely to be clinically important.

Evidence from comparisons between other treatments and therapeutic ultrasound for chronic LBP were indeterminate and generally of low quality. There was little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. Based on low to moderate level evidence, therapeutic US does not provide any benefit compared to a placebo or advice, to laser therapy or when combined to exercise for treatment of rotator cuff tendinopathy. Ultrasound provided no additional benefit in improving pain and function in addition to exercise training in the management of knee osteoarthritis.

No trials at low risk of bias support the use of traction, stretching, or ultrasound therapy for chronic neck pain.

Overall, there was limited high quality evidence for the effectiveness of manual therapy. Most reviewed evidence was of low to moderate quality and inconsistent due to substantial methodological and clinical diversity.

No high-quality evidence was found, indicating that there is great uncertainty about the effectiveness of exercise and manual therapy for treatment of temporomandibular joint dysfunction.

For adults with nonspecific shoulder pain of variable duration, cervicothoracic spinal manipulation and mobilization, in addition to usual care may improve self-perceived recovery compared to usual care alone. For adults with subacromial impingement syndrome of variable duration, neck mobilization in addition to a multimodal shoulder program of care, provides no added benefit. Finally, for adults with grade I-II ankle sprains of variable duration, lower extremity mobilization, in addition to home exercise and advice, provides greater short-term improvements in activities and function over home exercise and advice alone (Southerst, 2015).

For patients with rotator cuff tendinopathy, based on low to moderate-quality evidence, manual therapy may decrease pain; however, it is unclear whether it can improve function. (Desjardins-Charbonneau, 2015).

The best available evidence indicates that exercise therapy (whether land-based or water-based) is more effective than minimal control in managing pain associated with hip osteoarthritis (OA) in the short term. Larger high-quality randomized controlled trials (RCT) are needed to establish the effectiveness of exercise and manual therapies in the medium and long term (Beumer, 2016).

Low quality evidence suggests clinically important long-term improvements in neck pain, function/disability, and global perceived effect, when manual therapy and exercise are compared to no treatment. High quality evidence suggests greater short-term pain relief than exercise alone, but no long-term differences across multiple outcomes for (sub) acute/chronic neck pain with or without cervicogenic headache. Moderate quality evidence supports this treatment combination for pain reduction and improved quality of life, over manual therapy alone for chronic neck pain and suggests greater short-term pain reduction when compared to traditional care for acute whiplash. Evidence regarding radiculopathy was sparse (Miller, 2010).

Both stretching exercise and manual therapy considerably decreased neck pain and disability in women with non-specific neck pain. The difference in effectiveness between the two treatments was minor. Low-cost stretching exercises can be recommended in the first instance, as an appropriate therapy intervention to relieve pain, at least in the short-term (Ylinen, 2007). Combining different forms of manual therapy with exercise is better than manual therapy or exercise alone (Hidalgo, 2017).

For the treatment of the diagnostic label Non-Specific Neck Pain, strong evidence of efficacy was only found for multimodal care (manipulation/mobilization and supervised exercises) (Tsakitzidis, 2013).

The Cochrane Back and Neck Group reported little confidence that massage is an effective treatment for LBP. Acute, sub-acute, and chronic LBP had improvements in pain outcomes with massage only in the short-term follow-up. Functional improvement was observed in participants with sub-acute and chronic LBP when compared with inactive controls, but only for the short-term follow-up (Furlan, 2015).

There are insufficient data to draw firm conclusion on the clinical effect of back schools, low-level laser therapy, patient education, massage, traction, superficial heat/cold, and lumbar supports for chronic LBP (Van Middelkoop, 2011).

A number of nonpharmacological, noninvasive treatments for low back pain are associated with small to moderate, primarily short-term effects on pain versus placebo, sham, wait list, or no treatment. Effects on function are generally smaller than effects on pain. More research is needed to understand optimal selection of treatments, effective combinations, and sequencing of treatments, and effectiveness of treatments for radicular low back pain (Chou, 2007; 2017).

Guidelines on treatment of LBP from the National Collaborating Centre for Primary Care found insufficient evidence for the use of interferential stimulation in LBP and recommended against its use for that indication (Savigny 2009).

In a systematic review and meta-analysis, Fuentes analyzed the available information regarding the efficacy of interferential therapy in the management of musculoskeletal pain. Interferential current alone was not significantly better than placebo or other therapy at discharge or follow-up (Fuentes, 2010).

The effectiveness of high-voltage, pulsed current treatments in humans as a means of controlling edema and post-traumatic pain has not yet been established.

Scientific evidence in peer review literature is lacking regarding the use, safety, improvement, or effectiveness on health outcomes for light emitting diode (infrared) therapy.

Documentation requirements:

The treatment plan or plan of care must include the clinical rationale for each service, a description of the service, the area of the body the service will be provided, goals for each service, and a time component, if indicated.

Contraindications: The use of ultrasound therapy is contraindicated for pregnant patients or patients with malignancy.

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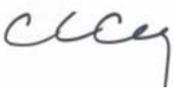
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