MAXIMUS Federal Services

Case Number:	CM13-0008246		
Date Assigned:	04/23/2014	Date of Injury:	12/29/2009
Decision Date:	07/29/2014	UR Denial Date:	07/29/2013
Priority:	Standard	Application Received:	08/06/2013

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. The expert reviewer is Board Certified in Emergency 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:

Patient with date of injury reported on 12/29/2009. Mechanism of injury was not provided, may be related to chronic occupational trauma. Documentation suggests prior low back injury. Diagnoses include: disc desiccation L2-S1, moderate disc herniation with moderate foraminal stenosis L4-5, L5-S1 and right lower extremity radiculopathy. Multiple medical reports from primary treating physician and consultants were reviewed. The injured worker has low back pain that worsens with bending, lifting, sitting and stooping. There is no activity of daily living (ADL) or pain scale documented. There is no documentation of any exacerbation or change in patient's baseline pain. The injured worker sees a pain management specialist but no report or any discussion of medication or pain management plan was provided. The objective exam reveals decreased range of motion due to pain and guarding with movement. Hyperextension causes pain radiating to right thigh. Muscle spasms are noted. Negative straight leg raise on left and positive on right leg. Electromyography (EMG) reveals right S1 radiculopathy. An MRI of the lumbar spine reveals disc dissociation and disc disease consistent with the documented diagnoses. An MRI of Cervical spine reveals C3-4 and C4-5 disc bulge with moderate neuroforaminal stenosis and C5-6 mild disc bulge. No central canal stenosis. There is documentation of prior management or interventions provided. There is no medication list provided in any of the documentation. Utilization review is for Aquatic Therapy x12 and Physical Therapy x12.Prior UR on 7/29/13 recommended non-certification of aquatic therapy and modified physical therapy to 4 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

AQUATIC THERAPY (X12): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: Aquatic therapy is an optional form of exercise therapy and is an option to land based therapy. As per chronic pain guidelines, it may be recommended in situations where decreased weight bearing is recommended. There is no documentation to support this criteria. There is no documentation indicating why the patient is not able to perform regular ground based exercise. As such, aquatic therapy is not medically necessary.

PHYSICAL THERAPY (X12): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL THERAPY..

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

Decision rationale: As per chronic pain guidelines, it may be recommended under certain circumstances. The patient has chronic low back pain, but there is no documentation of any exacerbation of pain. There is no change in patients activity. In fact there is contradictory assessments with one report stating that patient is able to work while another arguing that patient is permanent and stationary. Patient's pain is also chronic and injury happened years prior. There is no documentation of prior attempted physical therapy and what response patient had with these sessions. Treating physician documents signs of deconditioning, but there is no documentation of patient's home exercise and self guided physical therapy that patient likely was taught in prior PT sessions. While PT has good outcomes, it requires constant maintenance with a home PT regiment and home exercise routine or any and all gains will be lost. There is no documentation to support PT on this patient's chronic condition. The number of requested PT sessions is also excessive and not recommended by guidelines. The requested PT sessions are not medically necessary.