

<b>Case Number:</b>	CM13-0035884		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	07/23/2013
<b>Decision Date:</b>	02/17/2014	<b>UR Denial Date:</b>	10/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/18/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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:

The patient is a 45-year-old female who reported a work-related injury on July 23, 2013. The specific mechanism of injury was not stated. The patient presents for treatment of neck, thoracic, lumbar sprains and strains and thoracic or lumbosacral neuritis or radiculitis. The clinical note dated September 11, 2013 reports that the patient was seen under the care of [REDACTED]. The provider documents status post the patient's work-related injury she began occupational therapy to include stretching exercises, electrical muscle stimulation, Icy Hot packs, as well as 6 sessions of therapy directed to the mid and low back providing no relief of the patient's symptomatology. The provider documented that the patient stated the therapy provided aggravated her mid and low back symptoms. The provider documented upon physical exam of the patient, lumbar spine range of motion was noted to be at 29 degrees of flexion, extension 15 degrees, bilateral side bending 17 degrees. The provider documented no motor, neurological, or sensory deficits upon exam of the patient. The provider recommended the following treatment plan for the patient, use of Anaprox, Norco, and Fexmid, authorization for aquatic therapy 2 times a week for 4 weeks, authorization for acupuncture, and authorization for a home electrical muscle stimulation interferential unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**request for Aquatic Therapy: rehabilitation exercise program two (2) times per week for four (4) weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy.

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

**Decision rationale:** The clinical documentation submitted for review reports the patient had utilized a course of physical therapy status post a work-related injury sustained in July. The provider documented the patient completed 6 sessions of therapy, which the patient reported increased her pain symptoms. The California MTUS indicates aquatic therapy is recommended as an optional form of exercise therapy as an alternative to land based physical therapy. However, California MTUS also indicates to allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. Given that the patient reported poor efficacy with prior supervised therapeutic interventions, the request for Aquatic Therapy: rehabilitation exercise program two (2) times per week for four (4) weeks is neither medically necessary nor appropriate.

**request for a Home Electrical Muscle Stimulation/Interferential Unit, OrthoStim4:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic); and [www.vqorthocare.com](http://www.vqorthocare.com)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Microcurrent electrical stimulation (MENS devices) Section Page(s): 120.

**Decision rationale:** The clinical documentation submitted for review reports the patient recently presented to [REDACTED] for her cervical, thoracic, and lumbar spine pain complaints. The provider is recommending the patient utilize an interferential stimulation device; however, the California MTUS indicates this modality is not recommended as an isolated intervention. The Guidelines further indicate if this modality is to be utilized anyways, there must be documentation evidencing pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, history of substance abuse, or significant pain from postoperative condition limiting the ability to perform exercise programs, and unresponsive to conservative measures. The clinical notes document that the patient has utilized physical therapy times 6 sessions and a hot pack. Given that this modality is not supported as an isolated intervention, the request for a Home Electrical Muscle Stimulation/Interferential Unit, OrthoStim4 is neither medically necessary nor appropriate.