

Case Number:	CM13-0054485		
Date Assigned:	04/25/2014	Date of Injury:	02/19/2013
Decision Date:	06/11/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	11/19/2013

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:

This case involves a patient with a reported date of injury of 6/13/2012. There was no mechanism of injury provided. The patient has a diagnosis of osteoarthritis of the lumbar spine, displacement of lumbar disc, degenerative lumbar disc, and post laminectomy syndrome. There was a history of a lumbar fusion in 1/15/13. Multiple medical reports from the primary treating physician and consultants were reviewed. The last report was available until 10/15/13. The patient complained of lower back pain. The pain was dull, burning and intermittent radiating to the upper arms. There was numbness reported in both legs along with weakness. The pain worsens with prolonged sitting. The patient reports that with pain medications and physical therapy, she is able to perform her activities of daily living (ADL). The pain is rated 3/10. An objective exam reveals normal gait, with no significant pain. There was some pain from heel walking, paralumbar spasms and tenderness to palpation. There was diffusely decreased range of motion (ROM) of the lumbar spine. The straight leg raising was positive bilaterally. The bilateral lower extremity reflexes are absent. Light touch is decreased on the right leg and left feet. Motor strength is intact. The x-ray, MRI and electromyography (EMG) were done in the past; however, the reports were not provided. The urine drug screen from 7/24/13 reveals hydrocodone as prescribed. The patient is undergoing physical therapy. There was no medication list provided. There are notes from a pain management specialist that was provided. The utilization review (UR) is for (8 additional) aquatic physical therapy to lumbar spine two (2) per week for four (4) weeks and Pain management for the lumbar spine. The prior UR on 11/12/13 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 ADDITIONAL AQUATIC PHYSICAL THERAPY TO THE LUMBAR SPINE, 2X4 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

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. The Chronic Pain Guidelines indicate that aquatic therapy may be recommended in situations where decreased weight bearing is recommended. The patient does not meet criteria for this. The patient appears to be doing well with the current standard physical therapy and is reporting improved pain and activities of daily living (ADLs). The medical records do not provide support of the benefit from the prior aqua therapy reportedly completed. Therefore, Aqua Therapy is not medically necessary.

PAIN MANAGEMENT FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN PROGRAMS(FUNCTIONAL RESTORATION PROGRAMS) Page(s): 30-34.

Decision rationale: The Chronic Pain Guidelines indicate that chronic pain programs are recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. The guidelines also indicate that patients should also be motivated to improve and return to work, and meet the patient selection criteria. The patient does not meet the criteria recommended for chronic pain management programs. The patient's pain seems well controlled on a normal dosage of pain medications and the patient reports an improvement in activities of daily living (ADLs). There is no report of pain medication failure. Pain management as requested is not medically necessary.