

<b>Case Number:</b>	CM14-0017145		
<b>Date Assigned:</b>	04/14/2014	<b>Date of Injury:</b>	12/17/2011
<b>Decision Date:</b>	05/29/2014	<b>UR Denial Date:</b>	01/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/11/2014

### 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 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 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:

The patient is a 26 year old female who was injured on 12/17/2011 while lifting a case of oil. Prior treatment history has included physical therapy, chiropractic treatment, acupuncture, Motrin, Norco, muscle relaxant, heat/cold, TENS unit, and lumbar brace. Diagnostic studies reviewed include EMG/NCV dated 09/20/2012 reveals a normal study. There is no electrodiagnostic evidence of a right or left lower extremity radiculopathy, plexopathy, or mononeuropathy. According to UR notes dated 01/07/2014, the patient had left low back pain radiating down the posterior leg to the knee. On exam, lumbar flexion is to 70 degrees to the ankles, extension to 20 degrees and lateral bending 30/30 degrees. Straight leg raises were negative. Sensation was decreased in the left ankle. Diagnosis is low back pain and left sciatica. Treatment plan is 6 sessions of water therapy visits, Norco, Ultram ER, Flexeril, Naprosyn, Prilosec and P&S. Permanent and stationary report dated 12/05/2012 documents on back examination, the patient has slight to moderate lumbar paraspinal muscle spasm. Examination of range of motion utilizing the dual inclinometer technique reveals sacral (hip) flexion of 45 degrees and true lumbar spine flexion of 31 degrees with slight pain; Extension is dramatically limited to 14 degrees with moderate pain; Lateral bending to 18 degrees on the right and painless; lateral bending to 15 degrees on the left with moderate pinching on the left; Rotation is 30 degrees bilaterally; Palpation of the lower back reveals moderate tenderness present about the lumbosacral junction. Palpation of the right sacroiliac joint reveals no tenderness. Palpation of the left sacroiliac joint reveals slight tenderness. Palpation of the sciatic notches reveals no tenderness bilaterally; supine straight leg raise is positive on the left at 70 degrees; crossed supine straight leg raise is negative on the right; Sitting straight leg raise is borderline positive at 90 degrees on the left. Examination of the bilateral lower extremities reveals evidence of right calf atrophy upon visual inspection bilaterally; Mid-thigh circumferences are 23 inches and

bilaterally symmetrical, measured six inches above the adductor tubercles. Maximal calf circumferences are 15-1/2 inches on the right and 16-1/2 inches on the left, revealing 1/2 of right calf atrophy of unclear clinical significance. Neurological examination of the lower extremities reveals intact and symmetrical deep tendon reflexes at the patellar and Achilles levels of 2+ intensity bilaterally; motor examination reveals good strength in all muscle groups tested, including the quadriceps, hamstrings, anterior tibialis, extensor hallucis longus, and evertors and plantar flexors of the foot. Sensory examination reveals vague numbness in the left leg, not clearly in an anatomic distribution. The patient has a mildly antalgic gait. She is able to heel walk and toe walk without increased pain or weakness. The patient should be encouraged to participate in an independent strengthening and stretching exercise program. If appropriate facilities are not available at home, a membership in a reputable gym or health facility should also be provided for up to twelve months on an industrial basis. She should also be allowed 12 further visits of physical therapy. The patient would benefit from the continued use of a TENS unit and a back brace, which are reasonable and appropriate on an industrial basis. She probably does not require a lumbar epidural injection. The ongoing use of medications, including anti-inflammatory agents, muscle relaxants, and narcotic analgesics, is reasonable and appropriate on an industrial basis. The patient is not a candidate for spine surgery.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**AQUATIC VISITS, QTY 6:** Upheld

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

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

**Decision rationale:** According to the CA MTUS guidelines, aquatic therapy is recommended as an optional form of exercise therapy, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The medical records do not demonstrate significant functional limitations are present. Also, she is not morbidly obese or of an advanced age, that would inhibit her ability to participate in land-based activities. It is not indicated that the patient would obtain any significant benefit with aquatic therapy over standard therapy. At this juncture, the patient's focus should be on utilization of a self-directed home exercise and activity program, which would not require access to aquatic facilities. The request for aquatic visits is not medically necessary.