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| Case Number: | CM14-0111656 | | |
| Date Assigned: | 09/16/2014 | Date of Injury: | 08/19/2004 |
| Decision Date: | 10/17/2014 | UR Denial Date: | 07/02/2014 |
| Priority: | Standard | Application Received: | 07/17/2014 |

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 Anesthesiology & Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 57-year-old female with a reported date of injury on 08/19/2004. The mechanism of injury was a fall. The diagnoses consisted of cervical discogenic disease with radiculopathy, lumbar discogenic disease with radiculopathy, and low back pain. The past treatments included pain medications, physical therapy, trigger point injections, and surgery. There were no diagnostic images submitted for review. The surgical history included cervical fusion of C4-7. The subjective complaints were neck pain and low back pain. The physical examination to the cervical spine revealed restricted range of motion and mild trapezial spasms. The lumbar spine evaluation revealed painful spasms and limited range of motion and a positive straight leg raise on the right and left. The medications consisted of Percocet, Flexeril, Gabapentin, naproxen, temazepam, and Cymbalta. The treatment plan was to order aquatic physical therapy. A request was received for aquatic physical therapy 2 times a week x6 weeks. The rationale for the request was not provided in the notes. The Request for Authorization form was not provided in the notes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic Physical Therapy 2x week X 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Aquatic therapy. Decision based on Non-MTUS

Citation Official Disability Guidelines, Treatment for worker compensation ,chapter low back - lumbar&thoracic

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

Decision rationale: The MTUS Chronic Pain Guidelines state aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable. As with conventional physical therapy, functional deficits must be demonstrated. The injured worker has chronic low back pain. There was no specific documentation regarding to why the injured worker would need aquatic therapy versus traditional land based physical therapy. The clinical notes documented decreased range of motion in cervical spine and lumbar spine; however, they did not provided range of motion values to be able to objectively determine functional deficits. In the absence of a rationale as to why aquatic therapy is needed over land based physical therapy and there were no objective measurable functional deficits documented in the physical examination, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.