

<b>Case Number:</b>	CM14-0113799		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	09/20/2011
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2014

### 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 Family 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 now 38-year old teacher reported pain in her neck, back, right hand, right knee, both legs, and abdomen after she slipped on a wet floor and fell into a split on 9/20/11. She also reported stress and crying spells. Her original treating physician treated her conservatively and released her to regular work on 12/16/11. According to one of the current provider's reports, the original provider felt that the patient was feigning illness after viewing sub rosa video in which she walked without a limp and used her right hand normally. She had claimed to have inability to use her hand at all as well as severe knee pain obligating her to limp during her previous exams with him. He ordered an MRI of the right knee which was performed 6/28/12 and which revealed mucoid degeneration and probable medial mensical tear. The original primary provider made the patient permanent and stationary on 8/29/12 and stated that she was able to perform her usual job, though he gave her some restrictions to avoid further damage to her knee. The patient subsequently changed her care to her current provider. The available notes from him begin on 8/3/13. He ultimately referred her to a surgeon, who performed arthroscopic R knee chondroplasty on 7/18/14. No meniscal tear was found at surgery. Per the surgeon's notes, she was scheduled to begin physical therapy (presumably land-based) on 7/30/14. She was on temporary total disability, and the surgeon felt she would reach maximal medical improvement about 10/18/14. The primary provider has seen the patient multiple times during 2013 and 2014, and has requested aquatic therapy at virtually every visit beginning 8/3/13. He does not specifically address why aquatic therapy is needed except that he feels it efficiently treats multiple injuries. On 6/9/14, he again requested aquatic therapy 2 times a week for 4 weeks, as well as psychiatric consultation for stress due to injury and claims. These requests were denied in utilization review on 7/3/14. A request was made for MRI 7/31/14, although at that point the patient had had surgery and presumably had started land-based physical therapy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Aqua therapy, 2 times a week for 4 weeks, lumbar spine/right knee, quantity 8.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy; Physical Medicine Guidelines Page(s): 22, 99. Decision based on Non-MTUS Citation Official Disability Guidelines Knee & Leg (updated 06/05/14), Physical medicine treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 9, 22.

**Decision rationale:** Per the guidelines cited above, all therapies are focused on the goal of functional restoration rather than merely the elimination of pain, and assessment of treatment efficacy is accomplished by reporting functional improvement. There is not a single mention of this patient's level of function anywhere in her primary provider's notes, and it appears unlikely that he actually knows what that level is. He has not provided any rationale for prescribing aquatic therapy, nor any plan for assessing its effectiveness. Aquatic therapy is recommended as an alternative to land-based therapy, specifically when reduced weight bearing is desirable, for example in extreme obesity. This patient is described as very thin in at least one note, so it seems unlikely that she would need aquatic therapy. In addition, the treating provider appears to be unaware that this patient has already started post-operative physical therapy, and that additional therapy would be redundant. Aquatic therapy is not medically necessary based on lack of evidence that it is necessary, as well lack of any plan for assessing its efficacy.

**Psych consult quantity 1.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College Occupational and Environmental Medicine (ACOEM) Occupational Medicine Practice Guidelines, 2nd Edition, 2004, Page 27; Official Disability Guidelines (ODG) Mental Illness & Stress (updated 06/12/14) Office visits.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 391-398.

**Decision rationale:** Per the guideline cited above, treatment of stress should begin with a careful history and physical. The patient should be evaluated for mental illness, overwhelming symptoms or substance abuse. Presenting complaints often include multi-system, diffuse, or vague symptom complexes, and many of the symptoms associated with stress also may be symptoms of other physical or major psychiatric disorders. The history should include physical and emotional symptoms, perceived causes of stress and their meaning to the patient, coping mechanisms, as well as an evaluation of the patient's needs, risks and perceived level of function. Only by attempting to identify all principal areas of stress and dysfunction can the clinician make

specific diagnoses and treatment recommendations. As with any other specialist referral, the referring physician is expected to provide a sufficient account of signs and symptoms such that medical necessity is established. Although psychiatric conditions are often multifactorial and complex, the major factors can be outlined by a non-psychiatric physician. The primary physician has documented no such assessment of this patient. He has documented no symptoms or exam. It is not even clear that this patient has work-related stress at this time. It is possible that what she is interpreting as stress may be caused by a physical problem such as hyperthyroidism. Such a diagnosis would make referral for a psychiatric evaluation inappropriate. This referral is not medically indicated based on lack of appropriate assessment and lack of evidence of a psychiatric condition.