

<b>Case Number:</b>	CM14-0038123		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	05/10/2007
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	03/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2014

### 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 Arizona. 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:

Patient is a 38 year old female with a date of injury on 5/10/2007. Diagnoses include lumbosacral radiculopathy, status post hip surgery, chronic pain syndrome, and thoracic sprain. Subjective complaints are of upper and lower back pain, right hip pain, and bilateral knee pain. Physical exam shows use of a single point cane, positive right straight leg raise test, and decreased right calf/ankle sensation. MRI from 5/1/13 shows disc degeneration at L4-5 and L5-S1, and a small annular fissure at the L4-5 disc margin, without significant neural impingement. Records from 2/3/2014 show patient underwent a percutaneous peripheral nerve stimulator placement. Plan was for trigger point block, aqua and physical therapy, and consults with internal medicine, orthopedist, psych, pain medications, and a sleep study.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT LSP TRIGGER BLOCK:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRIGGER POINT INJECTIONS Page(s): 122.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRIGGER POINTS Page(s): 122.

**Decision rationale:** CA MTUS guidelines recommends trigger point injections for myofascial pain when trigger points are identified, symptoms have persisted for more than 3 months, and conservative treatments have failed including NSAIDS and muscle relaxants. Further criteria include no evidence of radiculopathy, and frequency of injections should not be greater than two months. Repeat injections are not recommended unless greater than 50% pain relief is obtained for six weeks and there is documented functional improvement. For this patient, documentation is not present of a positive trigger point response, and there is evidence of radicular symptoms. Therefore, the medical necessity for this request is not established at this time.

**Physical therapy 1 time per week for 6 weeks for the lumbar, right knee and right hip:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) KNEE, HIP, LOW BACK, PHYSICAL THERAPY.

**Decision rationale:** The ODG and CA MTUS recommends allowance for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. For lumbar sprains/strains and for intervertebral disc disorders the recommended physical therapy is 10 sessions over 8 weeks. For this patient, prior physical therapy has been completed without evidence of functional improvement. Furthermore, documentation is not present that indicates specific deficits for which additional formal therapy may be beneficial. Therefore, the medical necessity for 6 therapy sessions is not established at this time

**Aqua therapy 1 time per week for 6 weeks for the lumbar, right knee and right hip:**  
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 based on Non-MTUS Citation Official Disability Guidelines (ODG) PHYSICAL THERAPY, AQUATIC THERAPY.

**Decision rationale:** CA MTUS recommends aquatic therapy as an alternative to land based therapy specifically if reduced weight bearing is desirable, for example extreme obesity. The ODG recommends aquatic therapy as an optional form of exercise therapy, where available, 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. For this patient, there is no evidence of extreme obesity or presented rationale why land based exercise or therapy was not sufficient. Therefore, the medical necessity of aquatic therapy is not established.