

<b>Case Number:</b>	CM14-0076779		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	07/18/2009
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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 injured worker is a 56-year-old female who reported an injury on 07/18/2009. The mechanism of injury was an attack on the injured worker. The diagnoses included sciatica, cervical radiculopathy, carpal tunnel syndrome, and shoulder impingement. The previous treatments included medication and a back brace. The diagnostic testing included a CT scan, an EMG/NCV. Within the clinical note dated 08/06/2014, it was reported the injured worker complained of low back pain with bilateral leg radiation. She complained of numbness, tingling, and weakness of her right greater than left arms and legs. On the physical examination, the provider noted tenderness to palpation of the left lateral wrist, 3+/5 motor strength of the right arm, except 4-/5 right hand, 4/5 left arm and leg. The injured worker had decreased sensation to light touch of the bilateral lateral thigh and leg. The provider noted the injured worker had tenderness to palpation of the back, which was worsened with extension/flexion, rotation, lateral flexion. The injured worker had a positive straight leg raise on the right. The request submitted is for aquatic therapy, 8 sessions 2 times a week x4 weeks. However, rationale was not provided for clinical review. The Request for Authorization was provided and dated 05/14/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Aquatic Therapy QTY: 8 ...2 times a week for 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22. Decision based on Non-MTUS Citation ACOEM Guidelines Updated Back chapter 11/30/07.

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

**Decision rationale:** The California MTUS Guidelines recommend aquatic therapy only as an optional form of exercise therapy, where available, as an alternate to land-based therapy in those individuals in whom weightbearing is desirable. Guidelines note for neuralgia or myalgia, 8 to 10 visits of physical therapy are recommended. There is a lack of documentation indicating the injured worker had a condition for which reduced weightbearing would be desirable. There is a lack of documentation of motor deficits of the lower extremity. Therefore, the request is not medically necessary.