

Case Number:	CM14-0089920		
Date Assigned:	09/19/2014	Date of Injury:	06/06/2012
Decision Date:	10/17/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/13/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 54-year-old woman who sustained a work-related injury on June 12, 2012. Subsequently, she developed chronic neck, shoulder, back, and wrist pain. According to a report dated April 29, 2014, the patient reported right shoulder and upper extremity pain that varies from 6-7/10 without medications. In addition, the patient complained of depression, anxiety, and sleep disturbance. The patient stated that physical therapy has not been helpful. Her physical examination revealed multiple myofascial trigger points and taut bands noted throughout the cervical paraspinal, trapezius, levator scapulae, scalene, and infraspinatus muscles. The range of motion of the cervical spine was reduced. Spurling's test negative, Liermitt's test negative, and neck compression positive. The range of motion of the bilateral shoulders was reduced. The range of motion was reduced in the lumbar spine. Sensation to fine touch and pinprick was decreased in the 1st, 2nd, and 3rd digits of the right hand. Grip strength was decreased in the right hand at 4+/5. The proximal muscles of the right upper extremity were not tested well due to pain. Plantar response was down sloping. The patient was diagnosed with chronic myofascial pain syndrome, cervical spine; chronic sprain, right shoulder with internal derangement; right carpal tunnel syndrome; flexor tenosynovitis, status post lumbar spine surgery; polymyositis. The provider requested authorization for aquatic therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

AQUATIC THERAPY 2 X 6 FOR RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine.

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

Decision rationale: According to MTUS guidelines, aquatic therapy is <recommended 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 recommendations on the number of supervised visits, see Physical medicine. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities maybe required to preserve most of these gains. There is no clear evidence that the patient is obese or need have difficulty performing land based physical therapy or the need for the reduction of weight bearing to improve the patient ability to perform particular exercise regimen. There is no documentation of functional benefit from previous physical therapy sessions. There is no clear objective documentation for the need of aquatic therapy. Therefore the prescription of Aquatic Therapy 2 X 6 for Right Upper Extremity is not medically necessary