

<b>Case Number:</b>	CM14-0197621		
<b>Date Assigned:</b>	12/05/2014	<b>Date of Injury:</b>	03/02/1998
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	11/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 62 year old female who sustained a work related injury on March 2, 1998, incurring neck and back injuries. Diagnoses included cervical disc herniation and a cervical musculoligamentous injury. Treatment included cervical laminectomy, physical therapy, chiropractic manipulation and medications, patches and analgesic creams. Diagnoses made were degenerative joint disease of the cervical spine, cervical herniated discs, sacroilitis and radiculopathy and shoulder impingement syndrome. Currently, the injured worker, in May, 2014, complained of limited range of motion to the neck and arms with severe muscle spasms, headaches and blurry vision. She had cervical tingling and numbness with arm weakness. Magnetic Resonance Imaging (MRI) was remarkable for degeneration of the cervical spine with disc protrusion and spinal canal stenosis. On November 25, 2014, a request for a service of Hydro therapy of the cervical spine and a Solace Interferential Unit, monthly rental 30 minutes 3 to 5 times daily, was non-certified by Utilization Review, noting the California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydro therapy, cervical spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Aquatic Therapy does not seem appropriate as the patient has received land-based Physical therapy. There is no records indicating intolerance of treatment, incapable of making same gains with land-based program nor is there any medical diagnosis or indication to require Aqua therapy at this time. The patient is not status-post recent lumbar or knee surgery nor is there diagnosis of morbid obesity requiring gentle aquatic rehabilitation with passive modalities and should have the knowledge to continue with functional improvement with a Home exercise program. The patient has completed formal sessions of PT and there is nothing submitted to indicate functional improvement from treatment already rendered. There is no report of new acute injuries that would require a change in the functional restoration program. There is no report of acute flare-up and the patient has been instructed on a home exercise program for this injury. Per Guidelines, physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. Submitted reports have not adequately demonstrated the indication to support for the pool therapy. The Hydro therapy, cervical spine is not medically necessary and appropriate.

**Solace Interferential Unit, monthly rental unit, 30 mins 3-5 times daily:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, pages 115-118; Interferential Current Stimulation (ICS) Not rec.

**Decision rationale:** The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved work status derived from any transcutaneous electrotherapy to warrant an interferential unit for home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process with return to work and exercises not

demonstrated here. Submitted reports have not adequately demonstrated functional improvement derived from Transcutaneous Electrotherapy previously rendered. The Solace Interferential Unit, monthly rental unit, 30 mins 3-5 times daily is not medically necessary and appropriate.