

<b>Case Number:</b>	CM15-0007067		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	02/28/2014
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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 49 year old male who sustained an industrial injury, reported on 2/28/2014. He has reported difficulty with range-of-motion in the left shoulder. The diagnoses have included post-surgical left shoulder surgery (8/21/14); cervical disc protrusion; and lumbar foraminal narrowing. Treatments to date have included consultations; diagnostic and imaging studies; left shoulder surgery (8/21/14); physical therapy; and medication management. The work status classification for this injured worker (IW) was not noted. On 12/11/2014 Utilization Review (UR) non-certified, for medical necessity, the request, made on 12/5/2014; for range-of-motion and aqua therapy 2 x a week x 6 weeks for the neck, low back and shoulders. The Medical Treatment Utilization Schedule, chronic pain medical treatment guidelines, neck and upper back, low back, and shoulder complaints; and the American College of Occupational and Environmental Medicine for acute & chronic neck and upper back, low back - lumbar and thoracic, and shoulder; as well as non-Medical Treatment Utilization Schedule guidelines, were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Range of Motion (ROM):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation low back chapter, range of motion;flexibility

**Decision rationale:** This patient is status post left shoulder surgery on 08/21/2014 and continues to complain of left shoulder pain which has been aggravated by the cold weather. The current request is for range of motion ROM. This appears to be a request for range of motion testing. The request is unclear as there are no discussions regarding the request. The ACOEM, MTUS, and ODG Guidelines do not specifically discuss range of motion or strength test. However, ODG Guidelines under the low back chapter regarding range of motion does discuss flexibility. The ODG Guidelines has the following, "Not recommended as the primary criteria, but should be part of a routine musculo evaluation." The medical reports do not specify if this is a request for range of motion testing. ODG Guidelines considers examination such as range of motion part of a routine musculoskeletal evaluation, and the treating physician does not explain why a range of motion test is requested as a separate criteria. It should be part of an examination performed during office visitation. The requested range of motion IS NOT medically necessary.

**Start Aqua Therapy 2 times a week for 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Physical medicine Page(s): 22, 98-99.

**Decision rationale:** This patient is status post left shoulder surgery on 08/21/2014 and continues to complain of left shoulder pain that is aggravated by the cold weather. The current request is for start aqua therapy 2 times a week for 6 weeks. Progress report dated 11/05/2014 under treatment plan instructs the patient to complete post-op physical therapy and start home exercises. It is unclear why aquatic therapy is being initiated at this time. The MTUS Guidelines page 22, chronic pain medical treatment guidelines regarding aquatic therapy has the following, Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aqua 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 recommendation on number of supervised visits, the MTUS Guidelines page 98 and 99 recommends for myalgia and myositis type symptoms 9 to 10 sessions over 8 weeks. In this case, the treating physician has not discussed the need for weight-bearing exercises or extreme obesity to qualify the patient for water therapy. The patient is status post left shoulder surgery with complaints of bilateral shoulder pain and decreased range of motion. There are no physical deficits that would require weight-reduced exercises. In this case, there is inadequate explanation as to why aquatic therapy is necessary as opposed to home-based exercise program. This request IS NOT medically necessary.

