

Case Number:	CM15-0168851		
Date Assigned:	09/14/2015	Date of Injury:	07/25/2014
Decision Date:	10/13/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	08/27/2015

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 44 year old male, who sustained an industrial injury on July 25, 2014. Medical records indicate that the injured worker is undergoing treatment for left shoulder sprain-strain, left shoulder contusion, cervical spine sprain-strain, thoracic spine sprain-strain, lumbar sprain-strain, muscle spasms, cervical spine disc protrusion-desiccation, lumbar spine disc herniation, lumbar spine spinal stenosis, left shoulder supraspinatus partial tendon tear, left shoulder bursitis, anxiety and depression. The injured worker was not working as of June 30, 2015. Current documentation dated July 9, 2015 notes that the injured worker reported constant upper back pain, lower back pain and left shoulder pain rated 8 out of 10 on the visual analogue scale. The upper back pain radiated to the neck, bilateral shoulders, bilateral arms and bilateral hands. Associated symptoms included numbness and tingling. The low back pain was noted to be worsening and radiated to the bilateral lower extremities. Associated symptoms included numbness, tingling and a sharp sensation. The left shoulder pain radiated to the neck and upper back with associated numbness, tingling and weakness. Examination of the cervical spine revealed tenderness to palpation with spasms of the left upper trapezius muscle and left rhomboid muscle. Range of motion was limited secondary to pain. Orthopedic tests were negative. Lumbar spine examination revealed tenderness to palpation with spasms over the paraspinal and bilateral quadratus lumborum muscles. A straight leg raise test was positive. Left shoulder examination revealed tenderness to palpation with spasms and a limited range of motion secondary to pain. Subsequent documentation dated 6-30-2015, 5-26-2015 and 4-15-2015 note that the injured workers pain level was unchanged (8 out of 10) on the visual analogue

scale. Treatment and evaluation to date has included medications, radiological studies, multiple MRI's of various body parts and acupuncture treatments. Current medications include Tylenol # 3, Cyclobenzaprine and Pantoprazole. The treating physician's requested treatments include a request for aquatic therapy #12. The Utilization Review documentation dated August 14, 2015 non-certified the request for aquatic therapy # 12.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic therapy - 12 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Aquatic therapy.

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 functional 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 Aquatic therapy - 12 visits is not medically necessary and appropriate.