

Case Number:	CM15-0183592		
Date Assigned:	09/24/2015	Date of Injury:	04/05/2011
Decision Date:	10/29/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/18/2015

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 48-year-old female, who sustained an industrial injury on 4-5-2011. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar spine fusion 4-21-2015, left shoulder impingement syndrome, left shoulder AC joint arthrosis, left rotator cuff tear, chest contusion secondary to lumbar spine injury, and loss of sleep. On 8-10-2015, the injured worker reported constant moderate to severe dull, stabbing low back pain radiating to the tailbone and legs with weakness, and constant moderate to severe left shoulder pain, with loss of sleep due to pain, depression, anxiety, and irritability. The Primary Treating Physician's report dated 8-10-2015, noted the injured worker using a cane with lumbar spine range of motion (ROM) painful, and +3 tenderness to palpation of the lumbar paravertebral muscles and bilateral SI joints and muscle spasm of the lumbar paravertebral muscles. Straight leg raise was noted to cause pain. The left shoulder range of motion (ROM) was noted to be painful with +3 tenderness to palpation of the anterior shoulder, posterior shoulder, acromioclavicular joint, and trapezius with muscle spasm of the trapezius and Neer's noted to cause pain. Prior treatments have included physical therapy, acupuncture, massage, hot-cold packs, and medications. The treatment plan was noted to include aqua therapy. The physical therapy evaluation dated 8-10-2015, noted the injured worker complained of lumbar spine and left shoulder pain with activities of daily living (ADLs) at home and ambulation. A left shoulder MRI was noted to show a "tear". The treatment plan was noted to include aquatic therapy with goals to perform activities of daily living (ADLs) with 0 to minimum difficulty, decreased pain, increased strength, and increased active range of motion (ROM). The request for authorization dated 8-10-2015, requested unknown aquatic therapy visits. The Utilization Review (UR) dated 8-18-2015, non-certified the request for unknown aquatic therapy visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown aquatic therapy visits: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Low Back Complaints 2004, and 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 (surgery April 2015, over 6 months past) 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 Unknown aquatic therapy visits is not medically necessary and appropriate.