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| Case Number: | CM15-0187031 | | |
| Date Assigned: | 09/29/2015 | Date of Injury: | 06/09/2014 |
| Decision Date: | 11/06/2015 | UR Denial Date: | 09/16/2015 |
| Priority: | Standard | Application Received: | 09/23/2015 |

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:

This injured worker is a 66 year old female, who sustained an industrial injury on 06-09-2014. The injured worker was diagnosed as having acute cervical strain, acute lumbar strain. On medical records dated 08-10-2015, the subjective complaints were noted as cervical spine, lumbar spine right arm and left wrist and hand pain. Pain was noted as 7-9 out of 10 on pain scale and with medication a 5 out of 10. Objective findings were noted as cervical spine tenderness to palpation and spasm. Range of motion was noted as limited on flexion and extension and neurovascular status was intact distally. Lumbar spine was noted as having tenderness to palpation and spasms. Limited flexion, extension and rotation was noted, straight leg raise was positive on the right lower extremity. A treatment to date included medication and aqua therapy in the past but was unable to complete authorized number of sessions due to bronchitis. MRI of the Lumbar spine on 01-16-2015 revealed L5-S1 right foraminal disc protrusion in limited abutment of the exiting right L5 nerve root, L1-L2 and L5-S1 disc protrusion and mild facet arthropathy of the lower lumbar spine. The injured worker was noted to be temporarily totally disabled. Current medications were listed as Naproxen on medical record dated 08-10-2015. The Utilization Review (UR) was dated 09-16-2015. A Request for Authorization was dated 08-10-2015 for Aquatic therapy 2 times a week for 6 weeks (12 sessions) for the cervical and lumbar spine was submitted. The UR submitted for this medical review indicated that the request for Aquatic therapy 2 times a week for 6 weeks (12 sessions) for the cervical and lumbar spine was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic therapy 2 times a week for 6 weeks (12 sessions) for the cervical and lumbar spine:
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 2 times a week for 6 weeks (12 sessions) for the cervical and lumbar spine is not medically necessary and appropriate.