

Case Number:	CM15-0187630		
Date Assigned:	09/29/2015	Date of Injury:	03/01/2012
Decision Date:	12/03/2015	UR Denial Date:	08/25/2015
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:

The injured worker is a 64 year old female, who sustained an industrial injury on March 1, 2012. She reported pain in her neck, bilateral hands and low back from performing her regular work duties. The injured worker was currently diagnosed as having thoracic disc displacement, thoracic spine sprain and strain, lumbar disc displacement, lumbar facet hypertrophy and lumbar sprain and strain. Treatment to date has included diagnostic studies, trigger point injection with temporary relief and medication. A lumbar percutaneous stereotactic radiofrequency rhizotomy at L4-5 and L5-S1 levels was noted to provide a "long lasting affected" for approximately eight months. On June 22, 2015, the injured worker complained of constant, throbbing upper and mid back pain rated a 5 on a 1-10 pain scale. She also reported achy, burning low back pain with radiation to the bilateral legs with tingling. This pain was rated as a 2 on the pain scale. Physical examination of the lumbar spine revealed flexion 40 degrees, extension 15 degrees, left lateral bending 15 degrees and right lateral bending 15 degrees. Kemp's and bilateral straight leg raise were noted to cause pain. The treatment plan included aqua therapy two times a week for six weeks for the lumbar spine. On August 25, 2015, utilization review modified a request for aqua therapy two times a week for six weeks for the lumbar spine to aqua therapy eight visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aqua Therapy 2x6 for 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: Review indicates the request for aqua therapy was modified for 8 visits to transition to a home program. 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 2012 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 Aqua Therapy 2x6 for Lumbar Spine is not medically necessary or appropriate.