

<b>Case Number:</b>	CM15-0200785		
<b>Date Assigned:</b>	10/15/2015	<b>Date of Injury:</b>	04/18/2014
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	10/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

### 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 32 year old female, who sustained an industrial injury on 4-18-14. Medical records indicate that the injured worker is undergoing treatment for cervical spine sprain-strain, lumbar spine sprain-strain, right chest trauma (documented rib fracture) and costochondritis. The injured worker was noted to be temporarily totally disabled. On (8-26-15) the injured worker complained of constant mid-back, lumbar spine and neck pain. The neck pain radiated to the right upper extremity with associated numbness and tingling and an occasional tingling sensation of the face. Objective findings included tenderness of the cervicothoracic paravertebral region. The injured worker was also noted to have chest pain and labored breathing. The treating physician recommended aqua therapy. Treatment and evaluation to date has included medications, urine drug screen, electrodiagnostic studies, MRI's, radiological studies, chiropractic treatments, physical therapy and a home exercise program. Current medications include Norco and Ambien. The request for authorization dated 9-22-15 is for aqua therapy two times a week for six weeks to the back. The Utilization Review documentation dated 10-1-15 non-certified the request for aqua therapy two times a week for six weeks to the back.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Aqua therapy 2x6 for back: Upheld**

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

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

**Decision rationale:** The request aqua therapy 2x 6 for back is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy for conditions such as extreme obesity. The MTUS physical medicine guidelines recommend up to 10 therapy visits for this condition. The request exceeds this recommendation. The documentation does not indicate that the patient cannot participate in land-based therapy. There are no extenuating factors that necessitate 12 supervised aqua therapy sessions. The request for aqua therapy is not medically necessary.