

Case Number:	CM15-0207370		
Date Assigned:	10/26/2015	Date of Injury:	08/25/2010
Decision Date:	12/07/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/21/2015

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 66 year old female who sustained an industrial injury on August 25, 2010. Medical records indicated that the injured worker was treated for low back pain. Her medical diagnoses include lumbar disc disorder, lumbar radiculopathy and low back pain. In the provider notes dated from June 22, 2015 to September 30, 2015 the injured worker stated she has been working out in the pool and feels some benefit. She would like to know specific movements to help strengthen her back. She states since discontinuing working out in the pool she has been having severe muscles spasms. She rates her pain 6 out of 10 on a pain scale of 0 to 10. She has completed 10 sessions of physical therapy. On exam, the documentation noted limited range of motion in the lumbar spine. There was tenderness noted on lumbar 4 and both sides of the sacroiliac joint. The documentation states "on palpation, paravertebral muscles, hypertonicity, spasm and tight muscle band is noted on both sides." The heel and toe walk are normal. There is decreased sensation over the sacral 1 dermatomes of the right lower extremities. The treatment plan is to continue medications and aquatic therapy. Previous treatments include physical therapy, aquatic therapy, heat, low back stretches and medication management. A Request for Authorization was submitted for aquatic therapy 2 times a week for 6 weeks. The Utilization Review dated October 14, 2015 denied the request for aquatic therapy 2 times a week for 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic therapy 2 times weekly for 6 weeks, #12, low 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.

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 for this 2010 injury. 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 weekly for 6 weeks, #12, low back is not medically necessary or appropriate.