

<b>Case Number:</b>	CM15-0020907		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	07/13/2004
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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 58 year old male, who sustained an industrial injury on 07/13/2004. He has reported thoracic back pain. The diagnoses have included thoracic sprain/strain; T7-T12 disc degeneration; status post L4-S1 fusion 2010; and residual lower extremity paresthesias. Treatment to date has included medications and surgical intervention. Medications have included Lyrica, Norco, and Baclofen. Currently, the IW complains of continued thoracic spine pain, rated 0-4/10 on the visual analog scale; lower back pain which radiates into buttock and anterior thighs bilaterally, rated at 0-4 on the visual analog scale; and right foot pain and numbness, rated 0-3/10 on the visual analog scale. A progress report from the treating physician, dated 12/18/2014, reported objective findings to include palpable tenderness of the paravertebral muscles bilaterally, over the sacroiliac joints bilaterally; and in the interscapular space. The treatment plan included a prescription for Norco; updated x-rays of the thoracic spine; request for a short course of aquatic therapy, 2x3 to the thoracic spine; and follow-up evaluation as scheduled. On 01/07/2015 Utilization Review non-certified a prescription for Aquatic therapy twice a week for three weeks for the thoracic spine. The CA MTUS was cited. On 01/28/2015, the injured worker submitted an application for IMR for review of Aquatic therapy twice a week for three weeks for the thoracic spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Aquatic therapy twice a week for three weeks for the thoracic spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**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 with last surgery in 2010 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 work 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 twice a week for three weeks for the thoracic spine is not medically necessary and appropriate.