

<b>Case Number:</b>	CM15-0047427		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	11/04/1997
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational 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 69 year old female, who sustained an industrial injury on 11/04/1997. Diagnoses include status post bilateral total hip replacement, status post L4-5 and L5-S1 fusion and pubic symphysis arthralgia. Treatment has included medications, hardware injections and sacroiliac joint injections. Currently, the injured worker complains of left upper back pain and low back pain referring to the left more than right lower extremity. Treatment plan included Lidoderm brand patch, Robaxin, OxyContin ER, lab work and follow up in one month. The provider noted that aqua-therapy with driver assistance was still pending scheduling.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Aquatic therapy with transportation 1 time a week for 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic)Transportation (to & from appointments).

**Decision rationale:** The injured worker sustained a work related injury on 11/04/1997. The medical records provided indicate the diagnosis of status post bilateral total hip replacement, status post L4-5 and L5-S1 fusion and pubic symphysis arthralgia. Treatment has included medications, hardware injections and sacroiliac joint injections. The medical records provided for review do not indicate a medical necessity for Aquatic therapy with transportation 1 time a week for 6 weeks. The MTUS recommends aquatic therapy as an optional form of exercise therapy, as an alternative to land based physical therapy. The MTUS states, "Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity medicine." The official Disability Guidelines recommends transportation to and from appointments for those above 55 years of age with disabilities preventing them from self-transport and in need of nursing home level of care. Although the injured worker ambulates with walker, there is no indication from the documents reviewed that the injured worker needs nursing home level of care. Therefore, the request for Transportation is not medically necessary.