

<b>Case Number:</b>	CM15-0057735		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	05/15/2013
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	02/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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 44 year old female who sustained an industrial injury on 05/15/2013. Diagnoses include right knee pain, status post right knee chondroplasty, low back pain, bilateral wrist pain and right ankle pain. Treatment to date has included diagnostic studies, medications, physical therapy, crutches and status-post right knee chondroplasty on 03/17/2014. A physician progress note 02/12/2015 documents the injured worker has persistent right knee pain, low back and bilateral wrist pain. Her right wrist pain is worse and is describes as an achy type of pain with shooting pain. Her right knee pain is dull, achy with tightness. Pain level is 7 out of 10. She has an antalgic gait noted on the right. The treatment plan is for medications, and aquatic therapy. Treatment requested is for 1 tub of Lidocaine Gel 2%, 30ml, and 18 Aquatic Therapy Sessions for the low back, bilateral wrist, and right knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**18 Aquatic Therapy Session for the Low Back, Bilateral Wrist, and Right Knee:** Upheld

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

**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 last in March 2014 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 18 Aquatic Therapy Session for the Low Back, Bilateral Wrist, and Right Knee is not medically necessary and appropriate.

**1 Tub of Lidocaine Gel 2%, 30ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, page(s) 111-113.

**Decision rationale:** Chronic symptoms and clinical findings remain unchanged with medication refilled. The patient exhibits diffuse tenderness and pain on the exam to the spine and extremities with radiating symptoms. The chance of any type of topical improving generalized symptoms and functionality significantly with such diffuse pain is very unlikely. Topical Lidocaine is indicated for post-herpetic neuralgia, according to the manufacturer. There is no evidence in any of the medical records that this patient has a neuropathic source for the diffuse pain. Without documentation of clear localized, peripheral pain to support treatment with Lidocaine along with functional benefit from treatment already rendered, medical necessity has not been established. There is no documentation of intolerance to oral medication as the patient is also on other oral analgesics. The 1 Tub of Lidocaine Gel 2%, 30ml is not medically necessary and appropriate.

