

Case Number:	CM15-0087143		
Date Assigned:	05/11/2015	Date of Injury:	10/23/2008
Decision Date:	06/11/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	05/06/2015

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 51 year old female, who sustained an industrial injury on 10/23/08. Initial complaints were not reviewed. The injured worker was diagnosed as having facet hypertrophy lumbar; lumbar discogenic pain; lumbar radiculopathy, muscle spasms thoracic; musculoligamentous injury thoracic; lumbar stenosis; lumbar spondylolisthesis; status post right shoulder surgery (6/25/13 and 5/22/14); bursitis left shoulder; tendinitis left shoulder. Treatment to date has included lumbar epidural steroid injection (3/24/15); urine drug screening; medications. Currently, the PR-2 notes dated 1/23/15 are hand written and indicated the injured worker complains of lumbar spine pain that is constant, severe, sharp and radiates to the right lower extremity with numbness, tingling and weakness. He notes decreased range of motion for lumbar spine. She also complains of right shoulder pain. The notes document positive straight leg raises bilaterally with a diagnosis of lumbar radiculopathy. The treatment requested on this date was lumbar L4-5 epidural steroid injections that were completed on 3/24/15. On PR-2 notes dated 3/12/15, the injured worker is complaining of constant moderate to severe achy throbbing upper/mid back stiffness, heaviness and numbness radiating to the low back. The pain continues to radiate to both gluteal and both legs with numbness. She has constant moderate throbbing left shoulder pain with stiffness, heaviness, numbness and weakness radiating to neck and mid arm. She has right shoulder pain that is constant, moderate to sharp, throbbing, burning right shoulder pain, stiffness, heaviness, numbness, tingling, weakness and cramping radiating to the neck and mid arm. She also has loss of sleep, depression, anxiety and irritability due to pain. The provider has requested 1 Range of Motion and 12 Post-Operative Aquatic Therapy Sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Range of Motion: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Range of Motion (ROM).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, Independent Medical Examinations and Consultations, pages 137-138.

Decision rationale: Computerized ROM testing is not supported by MTUS, ODG, or AMA Guides. Evaluation of range of motion and motor strength are elementary components of any physical examination for musculoskeletal complaints and does not require computerized equipment. In addition, per ODG, for example, the relation between range of motion measurements and functional ability is weak or even nonexistent with the value of such tests like the sit-and-reach test as an indicator of previous spine discomfort is questionable. They specifically noted computerized measurements to be of unclear therapeutic value. Medical necessity for computerized strength and ROM outside recommendations from the Guidelines has not been established. The 1 Range of Motion is not medically necessary and appropriate.

12 Post-Operative Aquatic Therapy Sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Guidelines- Low Back - Lumbar & Thoracic (Acute & Chronic).

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 (only s/p lumbar epidural injection with 2 modified aquatic visits) 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 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 12 Post-Operative Aquatic Therapy Sessions is not medically necessary and appropriate.