

<b>Case Number:</b>	CM15-0112104		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	06/18/2014
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	06/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2015

### 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 46 year old female, who sustained an industrial injury on 6/18/14. She reported feeling a pull in her left leg and later experienced low back, left shoulder, left upper arm, and bilateral knee pain. Treatment to date has included physical therapy, home exercise program, medication, activity modification, acupuncture, electrodiagnostic testing, x-rays. Currently, the injured worker complains of constant neck and low back pain described as aching, sharp and stabbing, bilateral knee and wrist pain. The injured worker also reports left shoulder, bilateral elbow, wrist and hand pain with numbness, tingling and weakness. She reports symptoms are increased with reaching, grasping, gripping, repetitive motion and turning neck. The injured worker is currently diagnosed with cervical and lumbar radiculopathy. On examination, dated 4/20/15, tenderness to palpation in the lumbar and cervical spine paraspinal muscles there is also decreased range of motion noted. Electrodiagnostic test dated 4/8/15 revealed normal studies of the cervical spine and upper extremities (mild left and moderate right carpal tunnel syndrome was noted). A PR-2 dated 3/12/15 states bilateral knee pain 8/10, neck and low back pain 8/10. The note also states the cervical spine is tender at C6-C7, spasms and tenderness from T3-coccyx as well as a decrease in range of motion. The treatment plan included aqua therapy. A PR-2 dated 4/20/15 notes constant neck and low back pain, a decrease range of motion is also noted. A PR-2 dated 5/21/15 noted frequent and moderate in severity bilateral knee pain, frequent cervical spine pain with stiffness, lumbar pain frequent and moderate in severity, and bilateral wrist pain frequent and moderate in severity. There is documentation of an evaluation for acupuncture; however no further documentation of

treatment or efficacy was provided. The injured worker remains totally and temporarily disabled. Aqua therapy is being requested to improve the injured workers range of motion and decrease/eliminate pain.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Aqua therapy x 12-18 for the cervical and lumbar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine, aquatic therapy.

**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 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 Aqua therapy x 12-18 for the cervical and lumbar is not medically necessary or appropriate.