

<b>Case Number:</b>	CM15-0118175		
<b>Date Assigned:</b>	06/26/2015	<b>Date of Injury:</b>	09/14/1999
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	05/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2015

### 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 female who sustained an industrial injury on 9/14/99. Diagnoses are chronic cervical strain; rule out disc herniation, chronic lumbar strain; rule out disc herniation, and headaches. In a progress report dated 5/5/15, the treating physician notes complaint of persistent pain in the neck and back. Pain is rated at 8/10 and radiates to both extremities. Pain is made better with rest and medications. Motrin helps get the pain from a 9 down to a 5 and allows her to ambulate for 30 minutes. She uses a cane or walker. Work status is that she is not currently working. Exam of the lumbar spine reveals decreased range of motion. Palpation of the lumbar paraspinal and quadratus lumborum revealed tenderness and hypertonicity bilaterally. Straight leg raise test is positive bilaterally. She is unable to heel and toe walk bilaterally. Sensation was decreased in the L5 nerve distribution on the right and in the S1 nerve distribution bilaterally. Exam of the shoulders revealed decreased range of motion and tenderness to palpation bilaterally. Supraspinatus, Neer's and Hawkin's impingement tests were positive bilaterally. Current medication is Motrin. Previous treatment noted includes physical therapy, aquatic therapy, lumbar MRI, and epidural injections. The treatment plan is transportation to appointments, aquatic therapy, and Kera-tek analgesic gel. The requested treatment is 12 sessions of aquatic therapy 2 times a week for 6 weeks for the cervical/lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 sessions of aquatic therapy at 2 times a week for 6 weeks for the cervical/lumbar spine:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 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 chronic 1999 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 sessions of aquatic therapy at 2 times a week for 6 weeks for the cervical/lumbar spine is not medically necessary and appropriate.