

<b>Case Number:</b>	CM14-0059062		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	02/05/2014
<b>Decision Date:</b>	09/21/2015	<b>UR Denial Date:</b>	04/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2014

### 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 50 year old male who sustained a work related injury February 5, 2014. He slipped on a wet floor, falling backward and striking his head and back on the ground. He cannot recall if he lost consciousness and can only remember when he was being moved by security. X-rays were taken, physical therapy started and he was provided medication. An MRI of the lumbar spine was performed and therapy was discontinued due to a fracture in the lumbar spine. According to a primary treating physician's initial report, performed April 7, 2014, the injured worker presented with complaints of mid to low back pain and headaches. The headaches are on the right side of the head and right eye, with numbness and tingling on the side of the face and are intermittent with associated dizziness with positional changes. He reports relief with Tylenol. There are also complaints of constant mid back pain and sharp low back pain, with radiating pain into both legs to the feet, with numbness and tingling in the legs. Objective findings included; negative Spurling test, Tinel's sign is negative, bilaterally; lumbar spine- gait is normal and toe and heel walking is intact, range of motion flexion to 20 degrees, extension 15 degrees, right rotation 15 degrees and left rotation 10 degrees, right tilt 10 degrees and left tilt 5 degrees; straight leg raise, supine and seated position positive at 60-70 degrees on the right and left. X-rays taken of the lumbar spine, April 7, 2014, revealed narrowing at the L4-5 and L5-S1 and a non-displaced S3 fracture. Diagnoses are healing sacral fracture; lumbar spine discopathy; head trauma with resultant cephalgia. Treatment plan included referral to neurology, authorized, and at issue, a request for authorization for pool therapy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Pool Therapy two (2) times a week for four (4) weeks for the lumbosacral spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy; Physical Medicine 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 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 functional 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 Pool Therapy two (2) times a week for four (4) weeks for the lumbosacral spine is not medically necessary and appropriate.