

<b>Case Number:</b>	CM14-0039565		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	09/16/2002
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	03/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/04/2014

### 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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 70 year old female who was injured on 09/16/2002 due to a trip and fall. The injured worker reported cervical radiculopathy that was manifested by numbness and tingling in bilateral upper extremities. The injured worker had negative MRI of the brain. The injured worker suffered from chest pain but spontaneously resolved. Agreed medical report dated 09/09/10, indicated the injured worker having recurrent strokes and is hypertensive. Utilization review dated 03/07/14, resulted in a denial for continued use of Ultram as insufficient information had been submitted supporting continued use. The request for aquatic therapy and interferential unit also resulted in non-certifications as no information was submitted regarding inability to complete land based activities and no documentation was submitted confirming previous trial of transcutaneous stimulation unit. Clinical note dated 05/23/14 indicated the injured worker had been diagnosed with cervical musculoligamentous sprain/strain with left upper extremity radiculitis. There was an indication the injured worker also had complaints of low back pain radiating to the left lower extremity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Aquatic therapy for the neck, low back, and left knee, 3x4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

**Decision rationale:** The request for aquatic therapy for the neck, low back, and left knee three times a week for four weeks is not medically necessary. The injured worker previously underwent land based activities. CA MTUS guidelines note that aquatic therapy is indicated for injured workers who are unable to complete any land based therapeutic exercises. Given that no information was submitted regarding any exceptional factors that would indicate the injured worker having an inability to complete any additional land based activities, this request is not medically necessary.

**IF unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Page(s): 114-121.

**Decision rationale:** The request for an IF unit is not medically necessary. No information was submitted confirming previous month long trial of transcutaneous unit. No information was submitted regarding objective improvement with use of the trial. Given this, the request is not medically necessary.

**Ultram ER 150 mg #15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram), Page(s): 113.

**Decision rationale:** Patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of this medication cannot be established at this time. Therefore, the request is not medically necessary.