

<b>Case Number:</b>	CM13-0020938		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	07/16/2012
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	08/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/06/2013

### 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 Physical Medicine and Rehabilitation 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:

This patient sustained an injury on 7/16/12 while employed by the [REDACTED]. Request(s) under consideration include Physical therapy for the neck (12 sessions) and Fioricet #50. Diagnoses include cervical myofascial repetitive strain/sprain/ discogenic pain with bilateral upper extremity radiculopathy status/post corpectomy and fusion; thoracic discogenic pain; neuropathy of bilateral upper extremities; and insomnia. Report of 6/17/13 from the provider noted the patient with continuous chronic neck pain radiating to left upper extremity with numbness and tingling of the left 1st three digits. Patient noted physical therapy was authorized recently. Exam showed neck with tenderness on palpation, bilateral paracervical muscle tenderness with spasm; range in flex and rotation of 15 degrees; negative brachial tension test, DTRs 2+; motor strength of 4/5 bilaterally; with decreased sensation at 1st dorsal webspace on left. The patient remained temporarily totally disabled. Request(s) for Physical therapy for the neck (12 sessions) and Fioricet #50 were non-certified on 8/6/13 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the neck (12 sessions):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Physical Medicine Guidelines. Page(s): 98-99.

**Decision rationale:** 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. There are unchanged chronic symptom complaints and clinical findings without clear neurological deficits. 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 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. The employee reported therapy helping; however, without clear specific functional improvement in ADLs, work status, or decrease in medication and utilization without new injury, acute flare, or red-flag findings to support further treatment. The Physical therapy for the neck (12 sessions) is not medically necessary and appropriate.

**Fioricet #50:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Citation: Chronic Pain Medical Treatment Guidelines, Butalbital.. Page(s): 23.

**Decision rationale:** The compound consists of a fixed combination of butalbital, acetaminophen and caffeine. Evidence supporting the efficacy and safety of this combination product in the treatment of multiple recurrent headaches is unavailable. Caution in this regard is required because butalbital is habit-forming and potentially abusable. Evidence based guidelines support treatment regimen upon clear documented medical necessity with demonstrated symptom complaints, clinical findings, and specific diagnoses along with identified functional benefit from treatment previously rendered towards a functional restoration approach to alleviate or resolve the injury in question. Submitted reports have not identified any such illness or disease process, in this case, of complex tension headaches, severe acute flare, new injury, or change in chronic musculoligamentous pain presentation to support for this barbituate. The request for Fioricet(Butalbital/APAP 50/325/40 mg tablet)# #50 is not medically necessary and appropriate.