

<b>Case Number:</b>	CM13-0048696		
<b>Date Assigned:</b>	06/09/2014	<b>Date of Injury:</b>	08/04/2011
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2013

### **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 Anesthesiology, Pain Medicine and is licensed to practice in Florida. 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 58-year-old male with a reported date of injury on 08/04/2011. The mechanism of injury was not submitted within the medical records. His diagnosis was noted to include cervical degenerative disc disease. His previous treatments were noted to include physical therapy, medication, and activity modification. The progress note dated 03/21/2014 reported the injured worker complained of neck pain which radiated to the upper extremities to the elbows. The physical examination noted mild numbness to the right upper extremity and neck tenderness. The Request for Authorization Form was not submitted within the medical records. The request was for physical therapy 2 times per week for 5 weeks for the cervical spine and Mobic 7.5 mg; however, the provider's rationale was not submitted within the medical records.

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

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

#### **PHYSICAL THERAPY 2 TIMES PER WEEK FOR 5 WEEKS FOR CERVICAL SPINE:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical

Medicine, pages 98-99 Page(s): 98-99.

**Decision rationale:** The request for physical therapy 2 times per week for 5 weeks for the cervical spine is non-certified. The injured worker has had a previous 10 sessions of physical therapy. The California Chronic Pain Medical Treatment Guidelines recommend active therapy based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines state active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual, and/or tactile instructions. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The guidelines recommend for myalgia and myositis up to 10 visits over 8 weeks. There is a lack of documentation regarding current measurable functional deficits with range of motion and motor strength as well as quantifiable objective functional improvements with previous physical therapy. Additionally, the injured worker has received a previous number of 10 visits of physical therapy and the guidelines recommend 9 to 10 visits in which the request will exceed guideline recommendations. Therefore, the request is non-certified.

**MOBIC 7.5 MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, NSAIDS Page(s): 47.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, page 67 Page(s): 67.

**Decision rationale:** The request for Mobic 7.5 mg is non-certified. The injured worker has been taking this medication since at least 06/2013. The California Chronic Pain Medical Treatment Guidelines recommend NSAIDs for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular for those with gastrointestinal, cardiovascular or renovascular risk factors. The guidelines state with the utilization of NSAIDs there is no evidence of long term effectiveness for pain or function. The guidelines state NSAIDs are recommended as a second-line treatment for acute exacerbation of chronic pain and chronic low back pain. There is a lack of documentation regarding efficacy and improved function with utilization of this medication. The injured worker has been receiving this medication for over 6 months and the progress report dated 03/2014 reported Mobic was discontinued. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.