

<b>Case Number:</b>	CM13-0058450		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/01/2003
<b>Decision Date:</b>	05/05/2014	<b>UR Denial Date:</b>	11/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2013

### 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 Occupational 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic pain syndrome, chronic neck pain, and chronic shoulder pain associated with an industrial injury sustained on October 1, 2003. Thus far, the applicant has been treated with analgesic medications, muscle relaxants, transfer of care to and from various providers in various specialties, prior cervical laminectomy surgery, an apparent implantation of a spinal cord stimulator, and unspecified amounts of physical therapy over the life of the claim. A clinical progress note of October 31, 2013 is notable for comments that the applicant reports persistent neck pain radiating to the bilateral arms with associated numbness and tingling. The applicant has a history of chronic neck pain. The applicant has numbness about the hands and has some hypersensitivity to touch about the left L5 distribution. The applicant has reportedly been on Mobic for two years and has also been on baclofen for two years, it is further stated. It is stated that the applicant has not had any recent physical therapy. Mobic, baclofen, CT scan imaging of the cervical and lumbar spines, and aquatic therapy are endorsed. It does not appear that the applicant has returned to work. The applicant is described as significantly limited in terms of functional level and activities of daily living. An earlier note of October 22, 2013 is notable for comments that the applicant reports 8.5/10 left arm pain with associated neck pain. The applicant is also having headaches. The applicant is using a spinal cord stimulator. The applicant exhibits numbness about the left hand with well-preserved grip strength. 5/5 lower extremity strength is also appreciated. CT scanning of the cervical and lumbar spines is endorsed along with Mobic, baclofen, and aquatic therapy while the applicant is placed off of work, on total temporary disability.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**60 MOBIC 15MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

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

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines acknowledges that anti inflammatory medications such as Mobic represent the traditional first line of treatment for various chronic pain conditions, including the chronic low back pain reportedly present here; however, the applicant has used this particular agent since 2011 and has failed to achieve any lasting benefit or functional improvement. The applicant remains off of work, on total temporary disability, several years removed from the date of injury. The applicant remains highly reliant on various medications, treatments, spinal cord stimulator, etc. Continued usage of Mobic is not indicated in this context. Therefore, the request is not certified.

**A CT SCAN OF THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** The MTUS guidelines state that unequivocal evidence of neurologic compromise is sufficient evidence to warrant imaging studies in those applicants who do not respond to treatment and who would consider surgery an option were it offered to them. In this case, however, there is no unequivocal evidence of neurologic compromise. The applicant possesses well preserved lower extremity strength, despite having some dysesthesias about the left L5 distribution. There is no indication that the applicant is a surgical candidate insofar as the lumbar spine is concerned. Therefore, the request is not certified.

**A CT SCAN OF THE CERVICAL SPINE:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

**Decision rationale:** As noted in the MTUS-adopted ACOEM guidelines, CT scanning to validate a diagnosis of nerve root compromise, based on clear history and physical exam findings, in preparation for an invasive procedure is recommended. In this case, the applicant has

had a prior spinal cord stimulator implanted. The attending provider states that he needs to obtain CT scanning of the cervical spine to rule out a possible disk herniation versus misplacement of the spinal cord stimulator leads. The attending provider further states that he is concerned that the applicant may have a new or recurrent disk herniation following prior cervical laminectomy surgery. Thus, the applicant has numerous indications for cervical spine MRI imaging. Accordingly, the original utilization review decision is overturned. The request is certified.

**AQUATIC THERAPY TWICE A WEEK FOR EIGHT WEEKS FOR THE CERVICAL SPINE AND SHOULDER GIRDLE: 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 Page(s): 22,89.

**Decision rationale:** As noted in the MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy can be recommended as an optional form of exercise therapy in those applicants in whom land-based exercises or land-based therapy is contraindicated. In this case, however, there is no evidence that the applicant has any condition or conditions for which reduced weight-bearing is desirable. It is further noted that the 16-session course of treatment proposed by the attending provider represents treatment well in excess of the 9-to 10-session course recommended for myalgias and/or myositis of various body parts. Therefore, the request is not certified