

<b>Case Number:</b>	CM13-0036217		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	02/22/2006
<b>Decision Date:</b>	02/12/2014	<b>UR Denial Date:</b>	10/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/18/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois, Indiana, Texas. 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 physician 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 patient is a 52 year old female who reported an injury on 02/22/2006. The patient is currently diagnosed with severe pain in bilateral hands, right L5-S1 radiculopathy, lumbar spine degenerative disc disease and facet arthropathy, left shoulder rotator cuff syndrome with frozen shoulder syndrome, and chronic pain syndrome with anxiety and depression. The patient was seen on 11/04/2013. Physical examination revealed decreased lumbar range of motion, decreased left shoulder range of motion, tenderness to palpation, 5/5 motor strength in bilateral upper and lower extremities with the exception of bilateral FDP, finger abduction, and APB. The patient also demonstrated decreased sensation to pinprick in the right lateral thigh and posterior thigh and right hand. Straight leg raising was positive in the right lower extremity. Treatment recommendations included continuation of current medications and an EMG study of bilateral upper extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L-Spine MRI:** 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): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause including MRI for neural or other soft tissue abnormality. As per the clinical notes submitted, the patient has maintained a diagnosis of right L5-S1 radiculitis with lumbar spine degenerative disc disease and facet arthropathy. There is no significant change in the patient's physical examination when compared to previous office visits. The patient underwent an MRI of the lumbar spine following initial injury. Documentation does not reveal significant findings that necessitate a repeat MRI of the lumbar spine at this time. There has been little to no significant change in the patient's clinical presentation. Based on the clinical information received, the request for L-Spine MRI is non-certified.

**Rx Cymbalta 30mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 53.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

**Decision rationale:** The California MTUS Guidelines state antidepressants are recommended for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and psychological assessment. Cymbalta is FDA approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. It is also used off label for neuropathic pain and radiculopathy. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. The patient continues to demonstrate tenderness to palpation, diminished range of motion, diminished sensation, and positive straight leg raising. Satisfactory response to treatment has not been indicated by a decrease in pain, increase in function, change in the use of other analgesic medication, or improved quality of sleep and duration. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request for Rx Cymbalta 30mg is non-certified.

**Rx Neurontin 300mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

**Decision rationale:** The California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. As per the clinical notes submitted, the patient has continuously utilized this medication. Satisfactory response to treatment has not been indicated. The patient continues to report persistent pain. Physical examination continues to reveal diminished range of motion, tenderness to palpation, and diminished sensation with positive straight leg raising. Satisfactory response to treatment has not been indicated. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request for Rx Neurontin 300mg is non-certified.