

<b>Case Number:</b>	CM13-0043310		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	12/06/2003
<b>Decision Date:</b>	04/25/2014	<b>UR Denial Date:</b>	10/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2013

### 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 & Rehabilitation and is licensed to practice in 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 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 patient is a 60-year-old male who reported an injury on December 06, 2003. The patient has had continuing complaints of pain located all over the body, described as constant, electrical, numbness, tingling, and knife-like. The patient stated that his pain level is currently at a 5/10, which averages 5/10 to 6/10 as of December 31, 2013. The patient also describes having a poor sleep pattern, with an average of 4 hours to 5 hours of sleep per night. On the most current physical examination dated December 31, 2013, the patient was noted to have neurologically gross normal motor and sensory function noted, with the patient reporting no hypersensitivity or dysesthesia present. The patient also demonstrated full range of motion in all extremities, including the shoulder. He was positive for cervical spine tenderness with paraspinal muscle spasms and bilateral facet loading signs. Thoracically, the patient had tenderness with paraspinal muscle spasms and bilateral facet loading signs. In the lumbar spine, the patient had positive lumbar spine tenderness with paraspinal muscle spasms and bilateral facet loading signs. On assessment, the patient has been diagnosed with pain in limb, unspecified backache, pain in the joint to the lower leg, unspecified thoracic/lumbar neuritis/radiculitis, lumbosacral spondylosis, postlaminectomy syndrome of the lumbar region, and lumbago.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE CAUDIAL EPIDURAL STEROID INJECTION AND IV PUSH: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**Decision rationale:** According to California MTUS Guidelines, criteria for the use of an epidural steroid injection include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The patient must have also been initially unresponsive to conservative treatment to include exercises, physical methods, NSAIDs, and muscle relaxants. In the case of this patient, not only does he not have any prior MRIs or other diagnostic studies indicating the patient has radicular findings to corroborate with physical exam findings, the documentation also does not state that the patient has radiculopathy at this time as the most recent clinical documentation states the patient has grossly normal motor and sensory function. Lastly, there is a lack of adequate conservative modalities having been completed prior to undergoing an epidural steroid injection. As such, the requested service does not meet guideline criteria for an epidural steroid injection in the caudal region and is non-certified.

**MRI OF THE LUMBAR SPINE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** According to California MTUS and ACOEM, unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. The patient has been noted as having undergone a previous lumbar spine procedure. However, although the patient is having complaints of pain in the back, without having any red flag symptoms indicating the patient has neurologic deficits, a repeat MRI would not be considered medically necessary at this time. Furthermore, there is a lack of documentation providing objective findings from previous conservative methods of treatment prior to requesting an MRI of the lumbar spine. As such, the request cannot be supported at this time and is non-certified.

**X-RAY 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): 303-305.

**Decision rationale:** According to California MTUS Guidelines, lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six (6) weeks. In this case, the most current documentation does not indicate that the patient has any neurological deficits to indicate the medical necessity for an x-ray of the lumbar spine. As such, the requested service for an x-ray of the lumbar spine is not considered medically necessary.

**ONE PRESCRIPTION OF NEURONTIN 300MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-Epilepsy Drugs Page(s): 18.

**Decision rationale:** According to California MTUS Guidelines, Gabapentin is a first line treatment for neuropathic pain. The patient was previously noted to have used Neurontin. However, due to the physician having failed to indicate a number of tablets, frequency, and duration for use of this medication, the requested service cannot be certified at this time.

**A TENS UNIT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tens Page(s): 114-117.

**Decision rationale:** According to California MTUS Guidelines, use of a TENS unit is not recommended as a primary treatment modality, but a one (1) month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence based functional restoration for neuropathic pain and complex regional pain syndrome (CRPS) II. In the case of this patient, the physician has failed to indicate that this patient would be utilizing this as an adjunct to an evidence based functional restoration program, nor did the physician indicate the length of time the patient would be utilizing the TENS unit. Therefore, due to a lack of support from the guidelines and the lack of documentation meeting guideline criteria for the use of a TENS unit, the requested service cannot be supported at this time and is non-certified.