

<b>Case Number:</b>	CM15-0000053		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	09/30/2010
<b>Decision Date:</b>	03/05/2015	<b>UR Denial Date:</b>	12/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 48 year old female, who sustained an industrial injury on 08/30/2010. She has reported neck pain, low back pain, and right arm weakness. The diagnoses have included depressive disorder, incontinence, brachial plexus lesions, degenerative lumbar/lumbosacral intervertebral disc, lumbago, and headache. Treatment to date has included a previous ACD/IF (09/16/2006 and 05/05/2011) at the C4-C5 and C6-C7 levels, and medications. Currently, the IW complains of worsening low back pain, incontinence (a new complaint), and neck pain and right arm weakness. Diagnostic testing has included x-rays of the cervical spine (08/01/2014) showing stable post-operative changes with no interval changes or periprosthetic abnormality from a previous study (06/20/2012), and a MRI of the cervical spine (03/26/2013) showing straightening of the normal cervical lordosis, disc desiccation from C2-C3 down to C3-C4, a 1.9 mm C3-C4 disc bulge posteriorly with associated spinal canal narrowing, and post-surgical changes involving C4 down to C6 vertebral bodies which appears to be anterior surgical fusion. On 12/22/2014, Utilization Review non-certified a request for 1 MRI of the cervical spine, noting the absence of any physiologic evidence of tissue damage or neurologic dysfunction on a previous MRI (03/14/2014); no mention of any attempt at a strengthening program; and the absence of any scheduled invasive procedure of the cervical spine region. The ACOEM guidelines were cited. On 12/22/2014, Utilization Review non-certified a prescription for Neurontin 300mg #90, noting the absence of documentation of an adequate response to a previous use of this medication or a plan to switch to another anti-epilepsy drug (AED), and the previous modification of this medication to provide time for weaning. The MTUS was cited. On

12/31/2014, the injured worker submitted an application for IMR for review of MRI of the cervical spine, and 1 prescription for Neurontin 300mg #90.

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

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

#### **1 MRI (magnetic resonance imaging) 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): 177,178.

**Decision rationale:** MTUS Guidelines supports updated spinal MRI imaging if potential "red flag" conditions develop. The prior MRI showed some central spinal stenosis and the new onset of incontinence qualifies for a "red flag" condition. The request for the updated cervical MRI is supported by Guidelines under these circumstances. The cervical MRI was/is medically necessary.

#### **1 prescription for Neurontin 300mg, #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

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

**Decision rationale:** MTUS Guidelines supports the use of Gabapentin for individuals with these conditions. However, the Guidelines supports use only when there is clear evidence of meaningful benefit, which the Guidelines report to be about 30% improvement in pain. No reporting of pain or functional benefits is found in the medical records reviewed. Updated adequate documentation of benefits may support its use, but at this time and under these circumstances the Gabapentin does not meet Guidelines standards and is not medically necessary.