

<b>Case Number:</b>	CM15-0010484		
<b>Date Assigned:</b>	01/28/2015	<b>Date of Injury:</b>	06/26/2001
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	01/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/19/2015

### 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 47 year old female, who sustained an industrial injury on June 26, 2001. The injured worker was diagnosed as having status post anterior and posterior cervical fusion, status post posterior cervical fusion and decompression, lumbar discogenic disease, left lower extremity radiculopathy, and chronic pain syndrome. Treatment to date has included cervical spine MRI, lumbar spine MRI, cervical fusion, TENS, and medication. Currently, the injured worker complains of neck pain, worsening left arm pain, and worsening back pain, with left arm going numb. The Primary Treating Physician's report dated November 18, 2014, noted the examination of the cervical spine revealed spasm, pain, and decreased range of motion (ROM), with facet tenderness. Decreased sensation was present on the left at C5, with tenderness to palpation over the cervicotracheal ridge. Examination of the lumbar spine revealed spasm, painful range of motion (ROM), and limited range of motion (ROM), with positive Lasegue bilaterally. Positive straight leg raise was noted on the right at 90 degrees and on the left at 80 degrees. The Physician recommendations were noted to include continued use of a TENS unit, refilled medications including Neurontin, and Ambien, a request for a 3D CT scan to evaluate the placement of the hardware, and an injection was administered to the neck bilaterally using Celestone and Marcaine. Opioids and other pain related medications are managed by a different treating physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 600mg #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs Page(s): 16-19.

**Decision rationale:** MTUS Guidelines supports the use of Neurontin when there is a neuropathic pain syndrome and a trial has resulted in at least 30% improvement in pain. The continued prescribing of Neurontin does not meet the 30% improvement standard. In the records reviewed there is no documentation of any improvement in this individuals pain as a result of the use of Neurontin. In addition it is unusual for this class of medications to be prescribed by an orthopedic surgeon when other pain medications are managed by a pain specialist who does not document that Neurontin is being utilized by another physician. Under these circumstances the Neurontin 600mg #180 is not supported by Guidelines and is not medically necessary.

**CT Scan of Pelvis:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Hip & Pelvis Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 24, 25.

**Decision rationale:** The MTUS Guidelines recommend minimum standards of evaluation to justify requesting testing and treatment. In the records sent for review there is no documentation of an exam or symptoms specifically related to the pelvis. In addition, there is no documented differential diagnosis related to the pelvis. At this point in time, the request for the Pelvis CT scan is not adequately supported per Guideline standards. The CT scan of the pelvis is not medically necessary.