

<b>Case Number:</b>	CM15-0183873		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	06/11/2003
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	09/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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: Emergency 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:

This is a 62-year-old male with a date of industrial injury 6-11-2003. The medical records indicated the injured worker (IW) was treated for lumbar post-laminectomy syndrome and complication with neurological device. In the progress notes (5-27-15), the IW reported feeling anxious and having increased pain in the low back and leg. His pain pump was interrogated and it was discovered it had malfunctioned. On examination (5-27-15 notes), his mood was anxious; there was tenderness in the cervical and lumbar paraspinal muscles and pain over the bilateral L3 to S1 region and over the lumbar intervertebral spaces. Range of motion of the cervical spine was limited by pain and guarding and lumbar extension and anterior flexion caused pain. His gait was antalgic and he required a cane. Treatments included medications and implanted intrathecal pain pump. On 5-27-15, the provider refilled the IW's Tylenol #4, Zantac and Restoril and gave him prescriptions for Morphine sulfate IR 15mg, Clonidine 0.1mg and Valium 5mg until the pain pump could be replaced the following morning. The operative report dated 5-28-15 showed the intrathecal pain pump was replaced. There were no records submitted more recent than 5-28-15. No rationale was offered to support the request for the Clonidine or the lumbar ultrasound. A Request for Authorization was received for Clonidine 1000mcg per ml (quantity, duration and frequency unspecified), refills 0 and one ultrasound for the lumbar spine as an outpatient. The Utilization Review on 9-4-15 non-certified the request for Clonidine 1000mcg per ml (quantity, duration and frequency unspecified), refills 0 and one ultrasound for the lumbar spine as an outpatient.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Clonidine 1000mcg/ml (quantity, duration and frequency unspecified): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter updated 7/2015.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Clonidine, Intrathecal.

**Decision rationale:** As per MTUS Chronic pain guidelines, intrathecal clonidine can be used intrathecally synergistically with opioids. There is documentation of intrathecal pump failure and replacement. However, provider has failed to provide any recent documentation. Only documentation noted is pre-pump replacement and operative note. This request is assumed to be refill for intrathecal pump but the failure to provide documentation including prior efficacy of intrathecal clonidine along with appropriate, quantity, rate and assessment of side effects makes this request incomplete and cannot be safely approved. Not medically necessary.

**Ultrasound for the lumbar spine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back- Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back: Ultrasound, diagnostic (imaging).

**Decision rationale:** MTUS Chronic pain and ACOEM Guidelines do not have any sections that relate to this topic. As per Official Disability Guidelines, ultrasound is not recommended for the diagnosis of low back conditions. While it could be assumed that ultrasound is to aid in assessment or refill of intrathecal pump, the lack of any recent documentation fails to support request. Not medically necessary.