

Case Number:	CM14-0024241		
Date Assigned:	06/11/2014	Date of Injury:	07/01/2009
Decision Date:	07/15/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/26/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 53 year old male who was injured on 07/01/2009. He sustained an injury while lifting his hand as he was trying to grab something and he felt an electrical pain down his hand. Prior medication history included Neurontin, Gabapentin, Norco, and Soma. He was treated conservatively with 8 sessions of physical therapy and acupuncture. The patient underwent a cervical fusion C6-C7 in 1996, C5-C6 in 2004, Foraminotomy C7-T1, cervical fusion C7-T1 in 2009, Vicodin, Soma, metformin, Cialis, Niacin, Vesicare and mestinon. Diagnostic studies reviewed include MRI of the cervical spine dated 10/31/2013 revealed degenerative disk disease with retrolisthesis, C3-C4 and C4-5 with postoperative changes, C5 through T1, without canal stenosis or neural foraminal narrowing at the operative level. RFA dated 01/16/2014 documented the patient to have complaints of low back pain which he rated at 3/10 on the pain scale. He stated he had some increased stabbing into the low back region on the right side. He denied any new trauma. Pain management consultation dated 01/06/2014 reported the patient had complaints of back pain which he rated a 4-6/10 on the pain scale. He rated his neck pain a 6/10. He also reported constipation. He describes the pain as burning, stabbing with shooting numbness and pin and needles type symptoms in his bilateral upper extremities radiating to his fingers. On exam, he ambulated with an assistive device. He had tenderness to palpation over the left cervical and right paraspinal musculature. His range of motion is decreased in all planes of the cervical spine. Motor exam is 4+/5 on the left and 5/5 on the right. He had decreased sensation on the left but intact on the right. The treatment and plan included chiropractic/physiotherapy twice a week for 4 weeks. The patient was given Norco 10/325 mg. The patient is diagnosed with cervicalgia and chronic pain syndrome. Prior utilization review dated 02/18/2014 states additional chiropractic treatment x 8 cervical spine is denied as there are no documented objective gains from prior chiropractic therapy. The request for meds x1

Gabapentin 10% cream x 2 is denied as there is no documented evidence of failed oral management with Gabapentin or other anti-seizure medications to address neuropathy pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL CHIROPRACTIC TREATMENT X 8 CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: According to the CA MTUS guidelines, chiropractic treatment may be appropriate for treatment of chronic pain patient's in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. For therapeutic care of the low back, the guidelines recommend a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks may be recommended. Consideration for additional treatment interventions is not warranted, as there is no documentation of patient's response to previously authorized treatment (i.e. improvement in pain level, range of motion, strength or function). Therefore, the request for Additional Chiropractic Treatments is not medically necessary.

MEDS X1 GABAPENTIN 10% CREAM X 2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the CA MTUS guidelines, topical analgesics are an option with specific indications, many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. According to the guidelines, Gabapentin is not recommended for topical application. There is no peer-reviewed literature to support use and long term benefit. Therefore, the request is not medically necessary.