

Case Number:	CM15-0105762		
Date Assigned:	06/10/2015	Date of Injury:	03/10/2005
Decision Date:	07/15/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/02/2015

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: Physical Medicine & Rehabilitation

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 56 year old male, who sustained an industrial injury on 03/10/2005. The injured worker is currently permanent and stationary. The injured worker is currently diagnosed as having status post anterior cervical discectomy and fusion at C4-5, C5-6, and C6-7, and right upper extremity pain, status post right medial epicondylectomy with partial medial epicondylectomy and repair, and status post right radial nerve release, status post first rib resection, and history of medication induced gastritis. Treatment and diagnostics to date has included anterior cervical discectomy and fusion, electromyography/nerve conduction velocity studies of the bilateral upper extremities which showed mild carpal tunnel syndrome, cervical spine computerized tomography scan which showed degenerative disc disease and neural foraminal narrowing, chiropractic treatment with temporary relief, acupuncture and use of Transcutaneous Electrical Nerve Stimulation Unit with relief, physical therapy which did not help, cervical medial branch block, steroid injections, analgesic injections, and medications. In a progress note dated 12/10/2014, the injured worker presented with complaints of neck pain and right upper extremity symptoms. Objective findings include limited cervical spine range of motion with tenderness and decreased sensation to C5, C6, C7, and C8 dermatomes on the right. The treating physician reported requesting authorization for Gabapentin cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin Cream 1%, quantity unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 113.

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

Decision rationale: Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical cream over oral NSAIDs or other pain relievers for a patient with multiple joint pain without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic to include an anti-epileptic over oral formulation for this chronic injury without documented functional improvement from treatment already rendered. Guidelines do not recommend long-term use of this anti-seizure medication for this chronic injury without improved functional outcomes attributable to their use. The Gabapentin Cream 1%, quantity unspecified is not medically necessary and appropriate.