

Case Number:	CM15-0127781		
Date Assigned:	07/20/2015	Date of Injury:	07/11/2012
Decision Date:	08/19/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	07/01/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 35 year old male patient who reported an industrial injury on 7/11/2012. The diagnoses include lumbosacral protrusion with neural encroachment and radiculopathy. Per the progress notes dated 5/28/2015 and 6/25/2015, he had complaints of low back pain with right > left lower extremity symptoms. The physical examination revealed tenderness in the lumbar spine with decrease range-of-motion and positive straight leg raise. The medications list includes Hydrocodone, Tramadol and topical analgesic cream. He has had lumbar spine MRI dated 9/13/2012 which revealed degenerative changes at L5-S1. He has had lumbar epidural steroid injections - effective; "LSO" brace - effective but no longer fastens and unspecified numbers of physical therapy visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 6% in base, 300 grams topical: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

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

Decision rationale: Gabapentin 6% in base, 300 grams topical: Gabapentin is an anti convulsant. The cited Guidelines regarding topical analgesics state, "Largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended" "Topical NSAIDs- There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use.... Gabapentin: Not recommended. There is no peer-reviewed literature to support use." The cited guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Failure of antidepressants and anticonvulsants for this injury is not specified in the records provided. Intolerance to oral medication is not specified in the records provided. Gabapentin is not recommended by the cited guidelines for topical use as cited above because of the absence of high-grade scientific evidence to support their effectiveness. The medical necessity of Gabapentin 6% in base, 300 grams topical is not fully established for this patient. The request is not medically necessary.

Physical therapy x 12: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114, Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy Page(s): 98.

Decision rationale: Physical therapy x 12, the cited guidelines recommend up to 9-10 physical therapy visits for this diagnosis. Per the records provided, the patient has had an unspecified number of physical therapy visits for this injury. The requested additional visits in addition to the previously rendered physical therapy sessions are more than recommended by the cited criteria. There is no evidence of significant progressive functional improvement from the previous physical therapy visits that is documented in the records provided. Per the cited guidelines, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of physical therapy x 12 is not established for this patient at this time. The request is not medically necessary.