

Case Number:	CM15-0136461		
Date Assigned:	07/24/2015	Date of Injury:	02/05/2009
Decision Date:	08/21/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/14/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 52 year old male, who sustained an industrial injury on 2/05/2009. The medical records submitted for this review did not include documentation regarding the initial injury. Diagnoses include knee pain, pain in joint, lower leg. Treatments to date include oral medication and a steroid injection to the joint. Currently, he complained of low back and left lower extremity pain. Pain was rated 6/10 VAS with medication and 9/10 VAS without medication. The records documented he was able to work full time and had increased functional ability with the medications. On 6/26/15, the physical examination documented restricted range of motion in bilateral knees with crepitus and tenderness. There was decreased sensation noted in bilateral feet. The plan of care included Voltaren 1% gel #3 with one refill; Neurontin 300mg #90 with one refill; and Duragesic Patch 25mcg/hr #5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1 % gel Qty 3 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren (Diclofenac) gel.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, non-selective NSAIDS Page(s): 111, 107.

Decision rationale: Voltaren Gel (Diclofenac) is a non-steroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis. There is no evidence of lower extremities osteoarthritis. Voltaren efficacy was not studied in spine and shoulder pain and not in chronic pain. Therefore, request for Voltaren 1 % gel Qty 3 with 1 refill is not medically necessary.

Neurontin 300 mg Qty 90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

Decision rationale: According to MTUS, Neurontin has been shown to be effective for the treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered to be first line treatment for neuropathic pain. Continuous use of Neurontin cannot be certified without documentation of efficacy. There is no documentation of neuropathic pain, flare of pain or previous response to neurontin in this case. Therefore, the request for Neurontin 300 mg Qty 90 with 1 refill is not medically necessary.

Duragesic patch 25 mcg/ hr, Qty 5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl transdermal system) Page(s): 68.

Decision rationale: Duragesic (Fentanyl transdermal system). Not recommended as a first-line therapy. Duragesic is the trade name of a Fentanyl transdermal therapeutic system, which releases Fentanyl, a potent opioid, slowly through the skin. It is manufactured by [REDACTED] and marketed by [REDACTED] (both subsidiaries of [REDACTED]). The FDA approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The patient continued to have pain despite the previous use of Fentanyl and other opioids. The patient was prescribed Duragesic without clear and objective documentation of function improvement. There is no recent documentation of tolerance to opioids. There is no documentation that the patient condition required around the clock opioid therapy. Therefore, the prescription of Duragesic patch 25 mcg/hr, Qty 5 is not medically necessary.