

Case Number:	CM15-0182224		
Date Assigned:	09/23/2015	Date of Injury:	09/26/1997
Decision Date:	11/10/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/16/2015

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 York

Certification(s)/Specialty: Anesthesiology

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 injured worker is a 67 year old female who reported an industrial injury on 9-26-1997. Her diagnoses, and or impressions, were noted to include: bilateral knee end-stage varus osteoarthritis; internal derangement of knee; lumbago; displacement of cervical and lumbar inter- vertebral discs without myelopathy; and disorders of bursae and tendons in shoulder region. Recent magnetic imaging arthrogram studies of the left shoulder joint on 2-26-2014; physical therapy; and rest from work. Her treatments were noted to include injection therapy, and medication management. The progress notes of 8-10-2015 reported: a follow-up visit; a bad reaction with Orthovisc injection but good with Synvisc; that her right knee surgery had been approved but no one had accepted her case; increased left knee pain since previous visit; lumbar spine pain; constant, severe bilateral knee pain and right ankle pain, rated 5 out of 10, that radiated to, and was associated with weakness in, the right leg; continued insomnia due to chronic knee pain; and itching from Prilosec. Objective findings were noted to include: no acute distress; an antalgic gait pattern without use of an assistive device; tenderness to the medial and inferior aspects of the knee patella, with full bilateral range-of-motion; and decreased deep tendon reflexes in the bilateral lower extremities. The physician's requests for treatment were noted to include: Sulcrafate 1 gram, twice a day, #60 for gastrointestinal reflux disease symptoms; Voltaren Gel 1% every 6 hours as needed, #3; Diclofenac XR 100 mg twice a day, #30 x 2; and Neurontin 100 mg x 7 capsules four times daily, #840, to address neuropathic pain. The Request for Authorization, dated 8-18-2015, was noted for: Sulcrafate 1 gram twice a day, #60; Voltaren Gel 1% every 6 hours as needed, #3; Neurontin 100 mg x 7 capsules four times daily; and Diclofenac XR 100 mg twice daily, #30 x 2. The Utilization Review of 3-25-2015 non-certified the requests for: Diclofenac XR 100 mg, #30 x 2; Sulcrafate 1 gram, #60; and Voltaren Gel 1%, #3; and modified the request for Neurontin 100 mg, #840, to #420.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sucralfate 1gm #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation "Sucralfate" Drugs.com Revised: 13 May 2013. Accessed 26 August 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine 2014.

Decision rationale: Carafate (Sucralfate) is a cytoprotective agent indicated for the treatment of duodenal ulcers, stress ulcers and gastrointestinal reflux disease (GERD). Unlike other medications used for the treatment of peptic ulcer disease, Carafate is a sucrose sulfate-aluminum complex that binds to the mucosa, thus creating a physical barrier that impairs diffusion of hydrochloric acid in the gastrointestinal tract and prevents degradation of mucus by acid. In this case, there is no documentation indicating the diagnosis the medication is prescribed to treat. The medical necessity for Sucralfate has not been established. The requested medication is not medically necessary.

Voltaren gel 1% #3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the California MTUS Guidelines, Voltaren Gel 1% (Diclofenac) is indicated for the relief of osteoarthritis in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The maximum dose should not exceed 32 g per day. The submitted documentation does not indicate the area of treatment. Additionally, the efficacy of the medication was not submitted for review, nor was it indicated that it helped with any functional deficits that the injured worker had to the knee. In addition, there was no dosage specified for the requested medication. Medical necessity for the requested topical gel has not been established. The requested 1% Voltaren Gel is not medically necessary.

Diclofenac XR 100mg #30 times 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Voltaren is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute pain and acute exacerbations of chronic pain. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient had prior use of NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective functional improvement. Medical necessity of the requested has not been established. The requested medication is not medically necessary.

Neurontin 100mg #840: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin (Neurontin).

Decision rationale: Gabapentin (Neurontin) is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The records document that the patient has reported radiculopathy related to his chronic low back condition, without evidence of neuropathic pain. There is no documentation of objective findings consistent with current neuropathic pain to necessitate the use of Gabapentin. In addition, there is no documentation of benefit from the previous use of Gabapentin. Medical necessity for Gabapentin has not been established. The requested medication is not medically necessary.