

Case Number:	CM14-0147148		
Date Assigned:	09/15/2014	Date of Injury:	05/09/2006
Decision Date:	10/27/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/10/2014

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 Occupational Medicine, and is licensed to practice in Iowa. 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:

This patient is a 54 year old employee with date of injury of 5/9/2006. Medical records indicate the patient is undergoing treatment for s/p ACL reconstruction, right knee; s/p meniscectomy; left knee sprain; chronic low back sprain; morbid obesity; history of diabetes; hypertension; history of reactive depression and dyspepsia from medication. Subjective complaints include continual extreme aggravation of pain starting with the neck causing headaches. The pain will at times go to a 8-9/10 and she will go to the ER. The pain radiates to the lumbar spine causing pain at the same level. She has extreme weakness in both arms and legs. At times the weakness is so great she cannot get out of bed. Her pain goes down to a manageable level with medication but then she gets constipated. Objective findings include walking with four point walker with wheels. The lumbar spine has severe tenderness throughout the paravertebrals, worse at L4-L5 and L5-S1. Patient has restricted flexion, extension and side to side tilt. The straight leg raise causes bilateral back pain from a sitting position at 45 degrees. The bilateral knee range of motion is unrestricted from full extension to 150 degrees of flexion with crepitus in the patellofemoral joint. The patella tracks normally. There is swelling on medial and lateral joint line. There is severe tenderness bilaterally on the medial joint line. She has valgus deformity of the knees and crepitus is positive. Patellar compression test is positive. Treatment has consisted of glucosamine/chondroitin sulfate; Neurontin; Dexilant; Nucynta; home exercise and waiting for PT authorization. The utilization review determination was rendered on 8/27/2014 recommending non-certification of Neurontin 300mg one p o bid, #60; Glucosamine 500mg/Chondroitin Sulfate 400mg on po bid #60; Dexilant 60mg one p o qd, #30 and Lisinopril 20mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 300mg one p o bid, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-22. Decision based on Non-MTUS Citation Chronic Pain, Anti-epilepsy drugs (AEDs) for pain, Gabapentin (Neurontin®)

Decision rationale: The MTUS considers Gabapentin as a first-line treatment for neuropathic pain and effective for the treatment of spinal cord injury, lumbar spinal stenosis, and post op pain. MTUS also recommends a trial of Gabapentin for complex regional pain syndrome. ODG states "Recommended Trial Period: One recommendation for an adequate trial with Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin, 2003) The patient should be asked at each visit as to whether there has been a change in pain or function. Current consensus based treatment algorithms for diabetic neuropathy suggests that if inadequate control of pain is found, a switch to another first-line drug is recommended." Additionally, ODG states that Gabapentin "has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain". Based on the clinical documentation provided, there is no evidence of neuropathic type pain or radicular pain on exam or subjectively. As such, the request for Neurontin 300mg one p o bid, #60 is not medically necessary.

Glucosamine 500mg/Chondroitin Sulfate 400mg on po bid #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 16-18, 50, 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate Page(s): 50.

Decision rationale: MTUS states "Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride (GH). (Richy, 2003) (Ruane, 2002) (Towheed-Cochrane, 2001) (Braham, 2003) (Reginster, 2007) A randomized, doubleblind placebo controlled trial, with 212 patients, found that patients on placebo had progressive joint-space narrowing, but there was no significant joint-space loss in patients on glucosamine sulphate. (Reginster, 2001) Another RCT with 202 patients concluded that long-term treatment with glucosamine sulfate retarded the progression of knee osteoarthritis, possibly determining disease modification. (Pavelka, 2002) The Glucosamine Chondroitin Arthritis Intervention Trial (GAIT) funded by the National Institutes of Health concluded that glucosamine hydrochloride (GH) and chondroitin sulfate were not effective in reducing knee pain in the study group overall; however, these may

be effective in combination for patients with moderate-to-severe knee pain. [Note: The GAIT investigators did not use glucosamine sulfate (GS).] (Distler, 2006) Exploratory analyses suggest that the combination of glucosamine and chondroitin sulfate may be effective in the subgroup of patients with moderate-to-severe knee pain. (Clegg, 2006)"Progress notes do indicate that the patient has had prior knee surgery, but the treating physician noted that the patient had full range of motion with out crepitus or tenderness. In addition, the treating physician did not specify the type of glucosamine. As such, the request for Glucosamine 500mg/Chondroitin Sulfate 400mg on po bid #60 is not medically necessary.

Dexilant 60mg one p o qd, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk

Decision rationale: Dexilant is the brand name version of dexlansoprazole, which is a proton pump inhibitor. MTUS states, "Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." And "Patients at intermediate risk for gastrointestinal events and no cardiovascular disease : (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44)." ODG states, "If a PPI is used, omeprazole OTC tablets or lansoprazole 24HR OTC are recommended for an equivalent clinical efficacy and significant cost savings. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec), pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). (Shi, 2008) A trial of omeprazole or lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line. According to the latest AHRQ Comparative Effectiveness Research, all of the commercially available PPIs appeared to be similarly effective. (AHRQ, 2011)." The medical documents provided do not establish the patient as having documented GI bleeding/perforation/peptic ulcer or other GI risk factors as outlined in MTUS. Additionally, there is no evidence provided to indicate the patient suffers from dyspepsia because of the present medication regiment. Per guidelines, Dexlansoprazole is considered second line therapy and the treating physician has not provided detailed documentation of a failed trial of omeprazole and/or lansoprazole. As such, the request for Dexilant 60mg #30, 1 capsule daily with 2 refills is not medically necessary.

Lisinopril 20mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Diabetes (Type 1, 2, and Gestational), Hypertension

Decision rationale: Lisinopril is an ACE inhibitor and it is used in the treatment of hypertension. ODG states "Recommend that blood pressure in DM be controlled to levels of 140/80, but 130 may be appropriate for younger patients if it can be achieved without undue treatment burden. Over 88% of patients with type 2 DM either have uncontrolled hypertension or are being treated for elevated blood pressure. Hypertension is not only more prevalent in type 2 DM than in the general population, but it also predicts progression to DM. Once hypertension is diagnosed, an individual is 2.5 times more likely to receive a DM diagnosis within the next 5 years, and the combination of hypertension and DM magnifies the risk of DM-related complications. It is recommended that blood pressure in DM be controlled to levels of 130/80 mm Hg, starting with lifestyle modification and diet, and including medications". The treating physician has not provided details of a trial and failure of lifestyle modifications, increased cardiac risk factors, and documentation of hypertensive vital signs. As such the request for Lisinopril 20mg #60 is not medically necessary at this time.