

Case Number:	CM13-0049983		
Date Assigned:	03/28/2014	Date of Injury:	08/31/2010
Decision Date:	04/25/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/22/2013

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 California. 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:

According to the records made available for review, this is a 40 year-old male with an 8/31/10 date of injury. At the time (9/6/13) of the request for authorization for retrospective (DOS: 10/1/13) Topamax (topiramate) 50mg #60 with refill and retrospective (DOS: 10/1/13) Effexor/Venlafaxine 37.5mg #30 with refill, there is documentation of subjective (6/10 pain overall in the back, feet and stomach, some burning sensation in the back) and objective (greater pain flexing than extending, slightly felt centrally into the left with some palpable spasm over the paraspinals on the left side, slight antalgic gait) findings, current diagnoses (thoracic strain/sprain, myelopathy thoracic, lumbar strain or sprain, discogenic pain, sacroiliitis NEC, lumbosacral radiculopathy, chronic pain syndrome, and piriformis syndrome), and treatment to date (TENS unit, PT, and medication including Topamax for over 3 months). Regarding retrospective (DOS: 10/1/13) Topamax (topiramate) 50mg #60 with refill, there is no documentation that other anticonvulsants have failed; functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with use of Topamax.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST (DOS: 10/1/13) TOPAMAX (TOPIRAMATE) 50MG #60 WITH REFILL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-INFLAMMATORY MEDICATIONS Page(s): 22,67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPIRAMATE (TOPAMAX) Page(s): 21.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when other anticonvulsants have failed, as criteria necessary to support the medical necessity of Topiramate. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of thoracic strain/sprain, myelopathy thoracic, lumbar strain or sprain, discogenic pain, sacroiliitis NEC, lumbosacral radiculopathy, chronic pain syndrome, and piriformis syndrome. Additionally, there is documentation of neuropathic pain. Furthermore, there is documentation of utilization of Topamax for over 3 months. However, there is no documentation that other anticonvulsants have failed. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with use of Topamax. Therefore, based on guidelines and a review of the evidence, the request for retrospective (DOS: 10/1/13) Topamax (topiramate) 50mg #60 with refill is not medically necessary.

RETROSPECTIVE REQUEST (DOS: 10/1/13) FOR EFFEXOR/VENLAFAXINE 37.5MG #30 WITH REFILL: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 80-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS Page(s): 13-14. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), ANTIDEPRESSANTS

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain, as criteria necessary to support the medical necessity of antidepressants. ODG identifies documentation of depression, as criteria necessary to support the medical necessity of antidepressants. Within the medical information available for review, there is documentation of diagnoses of thoracic strain/sprain, myelopathy thoracic, lumbar strain or sprain, discogenic pain, sacroiliitis NEC, lumbosacral radiculopathy, chronic pain syndrome, and piriformis syndrome. In addition, there is documentation of chronic pain. Therefore, based on guidelines and a review of the evidence, the request for retrospective (DOS: 10/1/13) Effexor/Venlafaxine 37.5mg #30 with refill is medically necessary.