

Case Number:	CM13-0054229		
Date Assigned:	12/30/2013	Date of Injury:	08/09/2006
Decision Date:	12/24/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/08/2013

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 Internal 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:

The patient is an injured worker who is status post cervical lumbosacral spine surgeries. Date of injury was 08-09-2006. Electromyography (EMG) and nerve conduction velocity (NCV) consultation report dated 7/8/13 documented neck pain radiating down on both arms and numbness and tingling. The patient complains of neck pain radiating down on both arms, right more than left, and numbness and tingling on the right more than the left arm. The patient reports that she suffered her injuries as a result of heavy lifting at work. The patient has neck pain radiating down the right more than the left arm with associated paresthesias. The patient had anterior cervical fusion in 2009, lumbar fusion in 2009, and spinal cord stimulator placement in 2011. Upper limbs NCV/EMG demonstrated mild bilateral median sensory demyelinating neuropathies across the wrist consistent with mild bilateral carpal tunnel syndrome, and acute right C6-7 radiculopathy. The pain management consultation October 3, 2013 documented subjective complaints of pain in her lower back that radiates down both lower extremities. The patient had a visit with the neurosurgeon, on August 7, 2013, who is recommending further surgical intervention in her lumbar spine, in the form of removal of retained metal at L5-S1 with extension of the fusion to the L4-5 level. The patient continues to complain of neck pain that radiates down to both upper extremities. The patient recently had electrodiagnostic studies of both upper extremities performed on July 8, 2013, which revealed acute right C6 radiculopathy with bilateral carpal tunnel syndrome. Objective findings were documented. She has an antalgic gait favoring the left lower extremity. On examination of the posterior cervical musculature reveals tenderness to palpation bilaterally with increased muscle rigidity. There were numerous trigger points which were palpable throughout the cervical paraspinal muscles, upper trapezius and medial scapular regions. She also had tenderness along the suboccipital regions bilaterally. She had significant decrease in her range of motion. There is tenderness to palpation along the

posterior lumbar musculature with decreased range of motion. Straight-leg raise is positive. Diagnoses were C5-6 and C6-7 anterior cervical discectomy and fusion March 2009, bilateral upper extremity radiculopathy, L5-S1 posterior lumbar interbody fusion November 2009, bilateral lower extremity radiculopathy left greater than right, and lumbar spinal cord stimulator implant March 31, 2011. Medications included MS Contin 30 mg, Norco 10/325 mg, Prilosec, Soma, Nortriptyline, and Topamax. The pain management consultation report dated November 22, 2013 documented the patient had been previously on Neurontin and Lyrica which were not effective.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topamax 25mg: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs) Page(s): 16-21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), Topiramate (Topamax) Page(s): 16-22, 113.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs (AEDs) are recommended for neuropathic pain (pain due to nerve damage). Topiramate (Topamax) has been shown to have variable efficacy. Topiramate (Topamax) is considered for use for neuropathic pain when other anticonvulsants fail. Medical records document neuropathic pain. Electromyography (EMG) and nerve conduction velocity (NCV) consultation report dated 7/8/13 demonstrated mild bilateral median sensory demyelinating neuropathies across the wrist consistent with mild bilateral carpal tunnel syndrome, and acute right C6-7 radiculopathy. Medical history included C5-6 and C6-7 anterior cervical discectomy and fusion, bilateral upper extremity radiculopathy, L5-S1 posterior lumbar interbody fusion, bilateral lower extremity radiculopathy left greater than right, and lumbar spinal cord stimulator implant. The pain management consultation report dated November 22, 2013 documented that previous trials of Neurontin and Lyrica were not effective. Per MTUS, anti-epilepsy drugs are recommended for neuropathic pain. Topiramate (Topamax) is considered for use for neuropathic pain when other anticonvulsants fail. MTUS guidelines support the use of Topamax (Topiramate). Therefore, the request for Topamax 25mg is medically necessary.