MAXIMUS Federal Services

Case Number:	CM13-0071587		
Date Assigned:	01/29/2014	Date of Injury:	05/16/2011
Decision Date:	06/02/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	12/30/2013

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 <EXPERT REVIEWER CERTIFICATION>, has a subspecialty in <SUBSPECIALTY> 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 employee of [redacted] and has submitted a claim for displacement of cervical intervertebral disc without myelopathy and right shoulder tendinitis associated with an industrial injury date of 05/16/2011. Treatment to date has included lumbar fusion in 1997 and 1998, epidural steroid injections, physical therapy, chiropractic care, TENS unit, and medications including Topamax, Vicodin, Relafen, and tramadol. Medical records from 2011 to 2014 were reviewed showing that patient complained of neck pain radiating to the right shoulder and arm. Most activities of daily living aggravated the pain. Physical examination showed tenderness and muscle tension at the right side of neck and right acromioclavicular joint. Range of motion of the cervical spine was decreased, as well as of the right shoulder towards abduction, 15% restricted towards internal rotation and 20% extension. Spurling was positive on the right. Motor strength, as well as sensory exam, was grossly normal. Utilization review from 12/18/2013 denied the requests for tramadol/apap 37.5/325mg, #90 due to lack of documentation on measurable analgesic benefit with its use; hydrocodone/apap 5/500mg, #30 because of lack of evidence on functional / vocational benefit with ongoing use; and topiramate (Topamax) 25mg, #60 due to lack of documentation on continued neuropathic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL APAP 37.5/325MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use Of Opioids..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. An appeal letter, dated 01/09/2014, stated that the request for tramadol apap was a retro request and that patient discontinued the medication since 01/09/2012. However, a progress report written on 08/24/2012 still documented its use. There was no evidence that the patient gained pain relief and improved functional status at the time of its use. Furthermore, the present request did not specifically state a retro type of request. Therefore, the request for tramadol apap 37.5/325mg, #90 is not medically necessary.

HYDROCODONE/APAP 5/500MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use Of Opioids..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 80.

Decision rationale: Page 78 of MTUS Chronic Pain Medical Treatment Guidelines states that there are 4 A's for ongoing monitoring of opiod use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. Page 80 states some of the cardinal criteria for continuation of opiod therapy include evidence of improved function, reduced pain, and /or successful return to work. The earliest documentation stating the use of Hydro/Apap 10/325mg was written in 2011. An appeal letter, dated 01/09/2014, stated that the request for hydro/apap was a retro request and that patient discontinued the medication since 01/09/2012. However, a progress report written on 08/24/2012 still documented its use. Medical records submitted for review did not specifically show that there was significant pain improvement at the time of its use (i.e. documented pain reduction in terms of pain scale and functional gains). Moreover, the present request did not specifically state a retro type of request. Therefore, the request for hydrocodone/apap 5/500mg, #30 is not medically necessary.

TOPIRAMATE-TOPAMAX 25MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22.

Decision rationale: As stated on pages 16-22 of the California MTUS Chronic Pain Medical Treatment Guidelines, anti-epilepsy drugs are recommended for neuropathic pain. Outcomes with at least 50% reduction of pain are considered good responses. The patient was prescribed with this medication as early as 2012. An appeal letter, dated 01/09/2014, stated that the request for Topamax was a retro request at the time when patient had radicular pain into the right upper extremity associated with tingling and numbness evidencing neuropathic pain. It further stated that patient reported pain relief and functional improvement associated to its use. However, it is unclear whether the use of this medication has resulted in functional benefits such as decreased pain scores (measured via pain scale) and increased ability to perform activities of daily living (i.e. specific activities noted). Specific reduction in pain using a pain scale is significant in order to document a good response from Topamax per the guidelines noted above. Moreover, the present request did not specifically state a retro type of request. Therefore, the request for topiramate (Topamax) 25mg, #60 is not medically necessary.