MAXIMUS Federal Services

Case Number:	CM14-0108560		
Date Assigned:	07/30/2014	Date of Injury:	08/05/2003
Decision Date:	09/09/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/09/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Texas. 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 injured worker is a 63 year old female injured on 08/05/03as a result of cumulative trauma while performing her normal job duties. Diagnoses include a Chronic Cervical Thoracic Strain, moderate to advanced Degenerative Disc Disease at C5 to C6, moderate Degenerative Disc Disease at C4 to C5, Left Shoulder/Scapula Pain, Left Elbow Cubital Tunnel Syndrome, and mild Bilateral Wrists Carpal Tunnel Syndrome. The most recent clinical documentation provided is dated 07/27/10 indicated the injured worker's medications included Depakote, Atenolol, Lorazepam, Fiorinol, and Darvocet. Physical examination revealed decreased range of motion in the cervical spine, mildly tender to palpation over the left trapezius, no topical spasm, sensation to light touch decreased in the right thumb and ring finger, left deltoid and left forearm medially and laterally, tenderness at the left deltoid insertion with appropriate range of motion, deep tendon reflexes 2+ throughout and motor strength 5/5. The initial request for Topamax 25mg quantity 60 was initially non-certified on 07/01/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topamax 25mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epileptic. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Other Antiepileptic Drugs, Topiramate.

Decision rationale: Following review of the records provided the request for Topamax 25mg quantity 60 is not supported as medically necessary. There were no recent clinical records submitted for review limiting the ability to substantiate the medical necessity of the requested medication. Additionally, the request lacked a frequency and number of refills to be provided. As such, the request for Topamax 25mg quantity 60 is not medically necessary.