

Case Number:	CM14-0112800		
Date Assigned:	08/01/2014	Date of Injury:	03/18/2009
Decision Date:	09/25/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/17/2014

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 Family 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 injured worker is a 47-year-old female patient who reported an industrial injury to the back on 3/18/2009, over five (5) years ago, attributed to the performance of her customary job tasks reported as feeling lower back pain while performing her job tasks and had to leave work. The patient is treated for lumbar spine sprain strain. The treating diagnoses were brachial neuritis or radiculitis; cervical spine DDD; cervical spine intervertebral disc displacement without myelopathy; dysthymic disorder; headaches; injury to the cervical nerve roots; injury to lumbar nerve root; lumbago; lumbar sprain/strain; sprain/strain unspecified site shoulder and upper arm; thoracic/lumbosacral neuritis/radiculitis and hypothyroidism. The patient was noted to be status post lumbar spine surgery x2 the last one on 1/10/2013. The patient was reported to complain of back, neck, left shoulder, and left leg pain. The objective findings on examination included normal mood and affect; no acute distress; SLR positive on the left; pain with range of motion of the lumbar spine; motor strength is grossly normal except for left lower extremity; sensation grossly intact except for left leg hypoesthesia at L5 and S1. The treatment plan for the patient included amitriptyline; Norco 10/325mg; OxyContin 20mg; Topamax 25mg for neuropathic pain; and Valium 10mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topamax 25mg # 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti epilepsy Drugs; Topamax Page(s): 16-18; 21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter--anti-epilepsy drugs.

Decision rationale: The patient was prescribed Topamax (Topiramate) as an adjunct for the treatment of postoperative neuropathic pain subsequent to the laminectomy/discectomy x2. There was no demonstrated medical necessity over the recommended first line AEDs for chronic neuropathic pain. The use of Topamax is recommended for neurogenic pain and for Migraine Headaches. The use of this medication for "neuropathic pain" is not consistent with the recommendations of the ACOEM Guidelines, and the Official Disability Guidelines for the treatment of postoperative pain if the first line AEDs has not been documented to have failed. The use of Topamax is consistent with the treatment of chronic neurogenic pain and the treatment of peripheral neuropathic pain for patients that are resistant to the first line AEDs. There is no demonstrated medical necessity for the prescription of Topamax for the effects of the cited mechanism of injury. Topamax is recommended for neuropathic pain (pain due to nerve damage (Gilron, 2006) (Wolfe, 2004) (Washington, 2005) (ICSI, 2005) (Wiffen-Cochrane, 2005) (Attal, 2006) (Wiffen-Cochrane, 2007) (Gilron, 2007) (ICSI, 2007) (Finnerup, 2007)). There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs, and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy (Attal, 2006). The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. Outcome: A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails (Eisenberg, 2007) (Jensen, 2006). After initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. AEDs are associated with teratogenicity, so they must be used with caution in woman of childbearing age. Preconception counseling is recommended for anticonvulsants (due to reductions in the efficacy of birth control pills) (Clinical Pharmacology, 2008). Therefore, the request is not medically necessary.