

Case Number:	CM14-0153690		
Date Assigned:	09/23/2014	Date of Injury:	04/02/2006
Decision Date:	10/24/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/19/2014

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 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:

The claimant was injured on 04/02/06 in a rollover accident with a UTV. Dilaudid and Topamax are under review. She was evaluated on 09/29/08. She struck her head with loss of consciousness. She described headaches and right shoulder pain. She was status post surgery for a torn rotator cuff. She was taking medications including Klonopin, Prilosec, Norco, Ativan, Lexapro, and Lamictal and was attending chiropractic visits. She had multiple complaints. The diagnoses on 05/29/08 included postconcussion head injury/headache, otalgia, trigeminal neuralgia, 2 level cervical disc bulges, status post right shoulder rotator cuff surgery, myofascial pain syndrome, cervical sprain, and decreased vision. Ongoing symptoms included difficulty with concentration, headaches, blurred vision, and abnormal gait. She had postconcussive syndrome. She underwent extensive neuropsychological and cognitive testing. She was diagnosed with a cognitive disorder and adjustment disorder. She also had sleep difficulty and was taking medications that could affect the testing. On 05/05/14, the provider's note indicated that she was taking Dilaudid, Prozac, Topamax, and headaches. She had a random drug screen test and was positive for were lorazepam. On 06/10/14, she reported ongoing headaches. She had some difficulty with short-term memory. She was doing some exercising. It was doubtful that further medication would be effective. Her mood was appropriate. She was clinically alert with fluent speech. She was on multiple medications but there is no mention of Dilaudid. A drug screen dated 07/15/14 revealed the presence of lorazepam which was consistent. She reported she had been having a severe headache for 3 weeks. Usually her pain was 4/10 but was up to 6/10 over the past few weeks. She had more tightness of the right side of her neck compared to the left and positive Spurling's on the right side. She had good range of motion of the shoulder and mild tenderness. She was using Topamax tablets at bedtime with some benefit. It was being titrated up. She was to continue Dilaudid for pain control, Prozac for depression

and lorazepam for anxiety. On 06/13/14, she had decreased cervical spine range of motion with myofascial trigger points in the cervical region. She was using Dilaudid for pain control, Prozac for depression, Topamax for headaches, and lorazepam for spasm. On 08/13/14 she had neck pain, right shoulder pain, and headaches that were constant. She had not received the Dilaudid in the past couple of months and this increased her pain from 4 to about 5 or 6/10. She stated she was only using the Dilaudid 2 mg as needed for severe pain. She was getting 50-60% improvement in her pain 20 minutes after taking it. She had anxiety and depression. She was alert and oriented and had a normal gait. She was given Topamax for headache prevention. She continued to require Prozac for depression and lorazepam for anxiety.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dilaudid 2 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain, Page(s): 110.

Decision rationale: The history and documentation do not objectively support the request for the opioid Dilaudid 2mg #60. The MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. MTUS further explains, "pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." There is also no indication that periodic monitoring of the claimant's pattern of use and response to this medication, including assessment of pain relief and specific evidence of functional benefit, has been or will be done. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. The claimant's pattern of use of Dilaudid is unclear other than she takes it. There is no evidence that a signed pain agreement is on file at the provider's office and no evidence that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. As such, the medical necessity of the ongoing use of Dilaudid 2mg has not been clearly demonstrated.

Topamax 20 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topamax
Page(s): 46.

Decision rationale: The history and documentation do not objectively support the request for Topamax 20 mg #120 for prevention of headaches. The MTUS state "antiepilepsy drugs (AEDs) are also referred to as anti-convulsants. 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." In this case, there is no evidence that Topamax is being used to treat neuropathic pain from nerve damage. Also, the claimant has been taking it for a prolonged period of time and states it helps but at every visit, she reports headaches that at constant and daily. There is no evidence of measurable objective or functional improvement that has occurred as a result of the use of this medication. The medical necessity of the continued use of Topamax 20 mg has not been clearly demonstrated.