

Case Number:	CM14-0021007		
Date Assigned:	02/21/2014	Date of Injury:	05/03/2012
Decision Date:	07/18/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/08/2014

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 patient is a 48-year-old female who has submitted a claim for lower back pain and upper and/or lower extremity pain; associated with an industrial injury date of 05/31/2012. Medical records from 11/12/2012 to 12/19/2013 were reviewed and showed that patient complained of back pain with radiation to lower extremities. Patient reports no side effects from current medications. Physical examination showed tenderness over the lower back. Range of motion was normal. Straight leg raise test was negative. DTRs and motor strength were normal. Sensation was decreased over the left lower extremity. Treatment to date has included medications, home exercise program, psychotherapy, toradol injection, and epidural steroid injections. Utilization review, dated 12/20/2013, denied the request for Methoderm because there was no documented failure of trials of antidepressants or anticonvulsants; and denied and modified the requests for Topiramate 50mg #80 and #60, respectively, to enable the provider to consider alternative first line options, as this medication is not a first line drug for neuropathic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

METHODERM 120 GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105,111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SALICYLATE TOPICALS, TOPICAL ANALGESICS Page(s): 105, 111. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, SALICYLATE TOPICALS.

Decision rationale: Menthoderm contains menthol and methyl salicylate. As stated on page 111 of the CA MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Page 105 states that while the guidelines referenced support the topical use of methyl salicylates. Regarding the menthol component, CA MTUS does not cite specific provisions, but the ODG states that the FDA issued an alert indicating that topical OTC pain relievers that contain menthol and/or methyl salicylate, may in rare instances cause serious burns. In this case, the patient was prescribed Menthoderm on December 2013. However, there was no documented failed trials with first-line antidepressants or anticonvulsants. Furthermore, the rationale of the request was not included in the medical records submitted. Therefore, the request for MENTHODERM 120GM is not medically necessary.

TOPIRAMATE 50 MG: QUANTITY 80: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPSY DRUGS Page(s): 16-21.

Decision rationale: Pages 16 to 21 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. 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. Lack of response may be a 'trigger' for switching to a different first-line agent or combination therapy. Outcomes with at least 50% reduction of pain are considered good responses. In this case, the patient complains of back pain with radiation to the lower extremities despite topiramate intake since August 2013. However, medical records submitted for review indicate inadequate pain control, and no objective evidence of functional improvement was presented. Therefore, the request for TOPIRAMATE 50 MG: QUANTITY 80 is not medically necessary.

TOPIRAMATE 50 MG: QUANTITY 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPSY DRUGS Page(s): 16-21.

Decision rationale: Pages 16 to 21 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. 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. Lack of response may be a 'trigger' for switching to a different first-line agent or combination therapy. Outcomes with at least 50% reduction of pain are considered good responses. In this case, the patient complains of back pain with radiation to the lower extremities despite topiramate intake since August 2013. However, medical records submitted for review indicate inadequate pain control, and no objective evidence of functional improvement was presented. Therefore, the request for TOPIRAMATE 50 MG: QUANTITY 60 is not medically necessary.