

Case Number:	CM14-0024761		
Date Assigned:	06/11/2014	Date of Injury:	07/19/2012
Decision Date:	07/21/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	02/26/2014

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 Physical Medicine & Rehabilitation, 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 46-year-old female who reported an injury on 07/19/2012. The mechanism of injury was not provided for review. The diagnoses included left sacroiliac joint dysfunction, chronic cervical sprain/strain, and chronic lumbar sprain/strain. Within the clinical note dated 01/21/2014, it was reported the injured worker complained of pain rated 7/10 to 8/10. She reported limited function due to pain and lack of sleep. Upon physical examination, the provider noted the injured worker had limited range of motion of the neck and shoulders. She had 5/5 strength on the right and 4/5 strength on the left lower extremity with functional range of motion. The provider indicated the injured worker had tenderness in the cervical spinous process and lumbar spinous process. The injured worker had decreased sensation to light touch on left to right. Within the clinical note dated 05/15/2014, it was reported the injured worker reported no side effects from current medications. The physical exam findings were unchanged. There were no prior conservative treatments or current medications documented in the medical records the provider requested Amrix for muscle spasms, Lunesta for insomnia due to pain, and Topamax for headaches. The Request for Authorization was submitted 05/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMRIX 15 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-66.

Decision rationale: The request for Amrix 15 mg #60 is not medically necessary. The injured worker complained of pain rated 7/10 to 8/10. She complained of limited function due to pain and lack of sleep. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. Muscle relaxants may be effective in reducing pain in muscle tension and increasing mobility. However, in most low back pain cases, they show no benefit beyond non-steroidal anti-inflammatories in pain and overall improvement. Also, there is no additional benefit shown in combination with non-steroidal anti-inflammatories. The efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. There is a lack of objective findings indicating the injured worker had muscle spasms. The submitted request does not provide the frequency of the medication. Additionally, the injured worker had been utilizing the medication since at least 07/2012, which exceeds the guideline recommendations of short term use of 2 to 3 weeks. Therefore, the request for Amrix 15 mg #60 is not medically necessary.

LUNESTA 3 MG #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN, INSOMNIA TREATMENT.

Decision rationale: The request for Lunesta 3 mg #30 is not medically necessary. The injured worker complained of pain rated 7/10 to 8/10. She complained of limited function due to pain and lack of sleep. The Official Disability Guidelines do not recommend Lunesta for long term use, but recommend it for short term use. The guidelines recommend that insomnia treatment be based on the etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed include sleep onset; sleep maintenance; sleep quality; & next-day functioning. There is a lack of clinical documentation indicating the injured worker was diagnosed with insomnia. The submitted request does not provide the frequency of the medication. Additionally, the injured worker had been utilizing the medication since at least 07/2012, which exceeds the guideline recommendations for short term use. Therefore, the request for Lunesta 3 mg #30 is not medically necessary.

TOPAMAX 25MG #120: Upheld

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

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

Decision rationale: The request for Topamax 25 mg #120 is not medically necessary. The injured worker complained of pain rated 7/10 to 8/10. She complained of limited function due to pain and lack of sleep. The California MTUS Guidelines recommend Topamax for neuropathic pain. The guidelines note Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of central etiology. It is still considered for the use of neuropathic pain when other anticonvulsants fail. 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. There is a lack of documentation indicating the injured worker was experiencing signs or symptoms of neuropathic pain. The submitted request does not provide the frequency of the medication. There is a lack of documentation indicating the injured worker tried and failed other anticonvulsant medications. The provider failed to document the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request for Topamax 25 mg #120 is not medically necessary.