

<b>Case Number:</b>	CM14-0194036		
<b>Date Assigned:</b>	12/01/2014	<b>Date of Injury:</b>	03/30/1998
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	10/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/19/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 who reported an injury on 03/30/1998. The mechanism of injury was not provided. The injured worker's diagnoses include pain in limb. The injured worker's past treatments include medications. There were no relevant diagnostic studies included in the documentation. The injured worker's surgical history included a right total knee arthroplasty performed on 01/05/2011 and a right shoulder replacement in 11/2000. On 09/18/2014, the injured worker complained of ongoing right knee and right shoulder pain. She was noted with almost full range of motion to the right shoulder. Upon physical examination, the injured worker was noted with no significant change. The injured worker's medications included Ultracet 37.5/325 mg, Prozac 20 mg, Topamax 50 mg, and Celebrex 200 mg. The request was for Ultracet 37.5/325 mg and Topamax 50 mg. The rationale for the request was not clearly provided. The Request for Authorization form was signed and submitted on 09/29/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(Retrospective DOS: 09/18/14) Ultracet 37.5/325 mg QTY: 360.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**Decision rationale:** The request for retrospective Ultracet 37.5/325 mg #360 is not medically necessary. According to the California MTUS Guidelines, continuation of opioid therapy may be recommended for patients with ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current quantified pain, the least reported pain over the period since last assessment, intensity of pain after taking the opioid, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids including pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug related behaviors. The guidelines note to continue opioids if the patient does return to work, and if the patient has improved functioning and pain. The injured worker reported ongoing right knee and right shoulder pain. The documentation did not include a complete and thorough pain assessment to include a current quantified pain. Upon physical examination, the injured worker was noted with no significant change. The documentation did not provide sufficient evidence of significant objective functional improvement as a result of the use of the medication. In the absence of documentation with sufficient evidence of significant objective functional improvement and documented evidence of an objective decrease in pain as a result of the medication, the request is not supported. Additionally, as the request was written, there was no frequency provided. Therefore, the request is not medically necessary.

**(Retrospective DOS: 09/18/14) Topamax 50mg QTY: 180.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate (Topamax, no generic available) Page(s): 21.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs Page(s): 21.

**Decision rationale:** The request for retrospective Topamax 50 mg #180 is not medically necessary. According to the California MTUS Guidelines, Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy and neuropathic pain and central etiology. It may still be considered for use for neuropathic pain when other anticonvulsants failed. The injured worker reported ongoing right knee and right shoulder pain. Upon physical examination, the injured worker was noted with no significant change. The documentation did not provide sufficient evidence of significant objective functional improvement or decrease in pain as a result of the medications. In the absence of documentation with sufficient evidence of a significant objective functional improvement or documented evidence of an objective decrease in pain as a result of the medication, the request is not supported. Additionally, as the request was written, there was no frequency provided. Therefore, the request is not medically necessary.