

<b>Case Number:</b>	CM15-0133614		
<b>Date Assigned:</b>	07/21/2015	<b>Date of Injury:</b>	12/17/2012
<b>Decision Date:</b>	08/18/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 44 year-old male patient who sustained an industrial injury on 12/17/2012. A primary treating office visit dated 12/12/2014 reported the patient with subjective complaint of having lower back pain that radiates to the right lower extremity. Current medications were: Butrans patches, Norco, and Neurontin. A pain management follow up visit dated 01/08/2015 reported subjective complaint of pain in the low back radiating to the right lower leg. Medications are unchanged. The impression found the patient with chronic myofascial sprain/strain of lumbosacral spine, industrial; multilevel degenerative disc disease; lumbar radiculopathy, right sacroiliac joint strain. The plan of care noted continuing with medications, home exercises, modified work duty and follow up in four weeks. At a visit dated 02/05/2015 the patient was deemed permanent and stationary and noted utilizing heat/cold application.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Topiramate 25mg #30:** 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 Topiramate Page(s): 21.

**Decision rationale:** According to the guidelines, Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. In this case, the claimant had been on opioids along with Topiramate. The medications were not providing adequate pain relief. The claimant was also known to have pain induced depression and failure of SSRIS was not noted. The chronic use of Topiramate is not medically necessary.

**OxyContin (OxyCodone) 20mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

**Decision rationale:** According to the MTUS guidelines, opioids are not indicated as 1st line therapy for neuropathic pain, and chronic back pain. They are not indicated for mechanical or compressive etiologies. They recommended for a trial basis for short-term use. Long-Term use has not been supported by any trials. In this case, the claimant had been on opioids for a prolonged period of time without significant improvement in pain or function. There was no mention of Tylenol, Tricyclic or weaning failure. No one opioid is superior to another. The continued use of Oxycontin is not medically necessary.