

Case Number:	CM15-0184662		
Date Assigned:	09/25/2015	Date of Injury:	01/07/1981
Decision Date:	11/02/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/21/2015

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: North Carolina

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:

This injured worker is a 54 year old female who reported an industrial injury on 1-7-1981. Her diagnoses, and or impressions, were noted to include: cervical disc degeneration, radiculopathy and facet arthropathy; herniated nucleus pulposus cervical spine, status-post cervical discectomy and fusion (3-14-12); cervicogenic headache; cervical pseudo arthrosis; right lumbosacral facet arthropathy; bilateral arm radicular pain; mild carpal tunnel syndrome; and myofascial pain syndrome. X-rays of the cervical spine were done on 10-23-2012 & 4-21-15; computed tomography scan of the cervical spine on 2-27-2013; a recent toxicology screening was noted on 7-9-2015; and no current imaging studies were noted. Her treatments were noted to include: physical therapy; acupuncture treatments; surgery; massage therapy; ice-heat therapy; medication management with opioid agreement and toxicology studies; and rest from work. The orthopedic progress notes of 7-2-2015 reported: persistent flare-ups of neck region pain, rated 4-5 out of 10, with radiating numbness to the upper extremities-hands, left > right, exacerbated with upward gazing, prolonged driving and activities of daily living; that she was not working; and that her medications were being dispensed and managed through the pain management physician. The objective findings were noted to include: that she was taking Percocet and Zofran and that her 6-10-2015 urine drug screen was consistent; the measurements of the bilateral JAMAR grip strength test; tenderness over the posterior cervical para-spinal and upper trapezius musculature, left > right, with cervical muscle spasms and myofascial trigger points and decreased, painful range-of-motion. The physician's requests for treatment were noted to include:

continued treatment by the pain management specialist, for pain medication management and needs, and continued medications per the pain management specialist. The pain management progress notes of 5-19-2015 noted: complaints of constant, radiating neck pain down the arms and to the occipital region, causing headaches; that her pain was exacerbated by heavy exertion and decreased by medication; that she was taking Percocet to decrease pain, because multiple over-the-counter agents failed; that Topamax for pain, Tizanidine for muscle spasms, and Movantic for opioid constipation were initiated, and that Percocet would continue for 1 more month because it had been authorized. The Request for Authorization for Topamax 50 mg and Nucynta 75 mg, through express scripts was not noted in the medical records provided. The Utilization Review of 9-4-2015 non-certified the requests for Topamax 50 mg and Nucynta 75 mg, through express scripts. The 5-19-2015 pain management progress notes indicated the initiation of Topamax 25 mg tabs, 1 every morning and 2 at hour of sleep, #90, for neuropathic pain. Neither request for, nor history of, Nucynta was noted in the medical records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

90 Topamax 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Anti-epilepsy drugs (AEDs) for pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

Decision rationale: The California MTUS section on the requested medication states: Topiramate (Topamax, no generic available) 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. Topiramate has recently been investigated as an adjunct treatment for obesity, but the side effect profile limits its use in this regard. (Rosenstock, 2007) The patient has neuropathic pain but there is no documentation of first line anticonvulsant therapy for neuropathic pain. Therefore, the request is not medically necessary.

90 Nucynta 75mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Tapentadol (Nucynta).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)

(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work. (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function or activity specifically due to the medication. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.