

<b>Case Number:</b>	CM15-0046225		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	10/05/2000
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	02/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 57 year old female sustained an industrial injury to bilateral knees and back on 10/5/00. Previous treatment included bilateral knee replacements, right knee revision, lumbar fusion, intrathecal pump implant, physical therapy and medications. In an office visit dated 2/15/15, the injured worker complained of pain to bilateral legs, neck, left shoulder, right buttock, thoracic spine, right hip, bilateral hands, bilateral knees, lumbar spine, bilateral groin and bilateral feet rated 8/10 on the visual analog scale. Current diagnoses included chronic pain syndrome, bilateral hip pain, bilateral knee pain, lumbar post-laminectomy syndrome, lumbar radiculopathy, lumbar spine pain, right trochanteric bursitis, paresthesia, bilateral knee osteoarthritis, chronic insomnia, depression and obesity. The treatment plan included requesting medications (Dilaudid, Zomig, Oxycontin, Valium, Topamax, Effexor, Flector 1.3% and Trazadone).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Topamax 100mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20-9792.26 MTUS (Effective July 18, 2009) Page 16-21 of 127. Regarding request for topiramate (Topamax), Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that 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. Within the documentation available for review, pain with medications is noted to decrease only to 8/10 and there is no identification of any specific objective functional improvement. Antiepileptic drugs should not be abruptly discontinued but unfortunately there is no provision to modify the current request. As such, the currently requested topiramate (Topamax) is not medically necessary.

**Effexor XR 37.5mg XR24H-CAP:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 Page(s): 13-16.

**Decision rationale:** Regarding the request for Effexor, guidelines state that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Within the documentation available for review, pain is noted to decrease only to 8/10 with medications and there is no identification of any objective functional improvement, reduction in opiate medication use, or improvement in psychological well-being. In the absence of clarity regarding those issues, the currently requested Effexor is not medically necessary.

**Flector 1.3%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Flector, CA MTUS states that topical NSAIDs are indicated for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. Within the

documentation available for review, none of the abovementioned criteria have been documented.  
Given all of the above, the requested Flector is not medically necessary.