

Case Number:	CM15-0056891		
Date Assigned:	04/01/2015	Date of Injury:	07/04/2000
Decision Date:	05/01/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/25/2015

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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 51 year old female, who sustained an industrial injury on 7/4/00. She has reported a neck and back injury. The diagnoses have included cervicalgia, depressive disorder, lumbosacral neuritis, and lumbar post laminectomy syndrome. Treatment has included medications, surgery, acupuncture, chiropractic, Epidural Steroid Injection (ESI), heat, ice, physical therapy, Transcutaneous Electrical Nerve Stimulation (TENS) and trigger point injection. The x-rays of the cervical spine were done on 2/23/11 and chest was done on 1/4/11. The current medications were noted. Currently, as per the physician progress note dated 2/17/15, the injured worker complains of neck and head pain and increased pain in the lumbar spine. She states that she is having flare-ups since last visit. She states that she takes Percocet for some relief and it makes the pain manageable. She reported lumbar spine pain rated 4/10 on pain scale, neck pain rated 5/10 on pain scale and unchanged and left hip increased pain rated 4/10 on pain scale. The pain was described as aching, sharp, shooting, spasm, burning, numbness and tightness. She reports difficulty with sleep due to pain. The physical exam revealed cervical spine tenderness with spasm and decreased sensation. The physician noted that the injured worker was to continue with current medications without change. The physician requested treatment/ treatments include/ included Topamax 100mg quantity 30, Percocet 10/325mg quantity 90, and Magnetic Resonance Imaging (MRI) of the Cervical Spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topamax 100mg quantity 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-21.

Decision rationale: The injured worker sustained a work related injury on 7/4/00. The medical records provided indicate the diagnosis of cervicalgia, depressive disorder, lumbosacral neuritis, and lumbar post laminectomy syndrome. Treatment has included medications, surgery, acupuncture, chiropractic, Epidural Steroid Injection (ESI), heat, ice, physical therapy, Transcutaneous Electrical Nerve Stimulation (TENS) and trigger point injection. The medical records provided for review do not indicate a medical necessity for Topamax 100mg quantity 30. Topiramate (Topamax) is an antiepileptic drug. Like other antiepileptic medications, they are recommended for treatment of neuropathic pain. However, their continued use is based on documented evidence of 30% improvement in pain control. Unlike other antiepileptic drugs, Topiramate is indicated for treatment of neuropathic pain when other antiepileptics have failed. Although the records indicate the injured worker has used this medication for sometime; the records indicate failed treatment with NSAIDs and other Antiepileptic drugs, there was no documentation of the percentage pain improvement from the use of this medication. Therefore, the request is not medically necessary.

Percocet 10/325mg quantity 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

Decision rationale: The injured worker sustained a work related injury on 7/4/00. The medical records provided indicate the diagnosis of cervicalgia, depressive disorder, lumbosacral neuritis, and lumbar post laminectomy syndrome. Treatment has included medications, surgery, acupuncture, chiropractic, Epidural Steroid Injection (ESI), heat, ice, physical therapy, Transcutaneous Electrical Nerve Stimulation (TENS) and trigger point injection. The medical records provided for review do not indicate a medical necessity for Percocet 10/325mg quantity 90. The MTUS recommends the use of the lowest dose of opioids for the short-term treatment of moderate to severe pain. The MTUS does not recommend the use of opioids for longer than 70 days in the treatment of chronic pain due to worsening adverse effects and lack of research in support of benefit. Also, the MTUS recommends that individuals on opioid maintenance treatment be monitored for analgesia (pain control), activities of daily living, adverse effects and aberrant behavior; the MTUS recommends discontinuation of opioid treatment if there is no documented evidence of overall improvement or if there is evidence of illegal activity or drug

abuse or adverse effect with the opioid medication. The records indicate she has been using opioids at least since 2012, but with no overall improvement in pain and function. She has remained off work; there is limited documentation of the features of the pain, she has stomach pain as a side effect of the medication. Therefore, the request is not medically necessary.

MRI of the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: The injured worker sustained a work related injury on 7/4/00. The medical records provided indicate the diagnosis of cervicalgia, depressive disorder, lumbosacral neuritis, and lumbar post laminectomy syndrome. Treatment has included medications, surgery, acupuncture, chiropractic, Epidural Steroid Injection (ESI), heat, ice, physical therapy, Transcutaneous Electrical Nerve Stimulation (TENS) and trigger point injection. The medical records provided for review do not indicate a medical necessity for MRI of the Cervical Spine. There was no documented evidence of neurological findings in the examination. The MTUS recommends against over reliance of imaging studies in order to avoid diagnostic confusion. The request is not medically necessary.