MAXIMUS Federal Services

| Case Number: | CM15-0084097 | | |
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| Date Assigned: | 05/06/2015 | Date of Injury: | 09/16/2003 |
| Decision Date: | 07/01/2015 | UR Denial Date: | 04/21/2015 |
| Priority: | Standard | Application Received: | 05/01/2015 |

## 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

## 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(n) 53 year old female, who sustained an industrial injury on 9/16/03. She reported pain in her shoulders, back, right arm and lumbar spine related to a fall. The injured worker was diagnosed as having lumbar degenerative disc disease, intradiscal pain and reactive myofascitis. Treatment to date has included Topamax (since 3/2014), Lidoderm 5% patches (since 3/14), Trazodone (since 3/2014), Methadone (since 8/2014) and physical therapy. As of the PR2 dated 1/15/15, the injured worker reports no new symptoms. She is being considered for surgical intervention but this authorization has not occurred as of yet. The treating physician administered an intramuscular injection at the visit due to uncontrolled low back pain. Objective finding include a positive straight leg raise test and decreased range of motion. The intramuscular injection provided a 60% reduction in pain. The treating physician requested Methadone 10mg #240, Topamax 200mg, Lidoderm 5% patches #2 and Trazodone 100mg.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Methadone 10 mg Qty 240 (30 day supply):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opiates Page(s): 76-78, 88-89.

**Decision rationale:** The patient was injured on 09/16/03 and presents with severe low back pain. The request is for Methadone 10 Mg Qty 240 (30 Day Supply). There is no RFA provided and the patient's work status is not provided. The patient has been taking this medication as early as 08/04/14. MTUS Chronic Pain Medical Treatment Guidelines pages 88-89, Criteria for use of opiates for long-term users of opiates (6 months or more) states, Pain should be assessed at each visit and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. MTUS page 78 criteria for use of opiates, ongoing management also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior) as well as pain assessment or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication for work, and duration of pain relief. The patient is diagnosed with lumbar degenerative disc disease, intradiscal pain, and reactive myofascitis. In this case, none of the 4 A's are addressed as required by MTUS Guidelines. The treater does not provide any before-and-after pain scales. There are no examples of ADLs which demonstrate medication efficacy, nor are there any discussions provided on adverse behavior/side effects. No validated instruments are used either. The patient was consistent with her two urine drug screens conducted on 10/08/14 and 11/20/14. There is no CURES report on file. No outcome measures are provided as required by MTUS Guidelines. The treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Methadone is not medically necessary.

**Topamax 200 mg (2 per day), unspecified qty:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti epilepsy drugs (AEDs) Page(s): 16, 21.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate (Topamax) antiepileptic drugs for chronic pain Page(s): 21, 16-17.

**Decision rationale:** The patient was injured on 09/16/03 and presents with severe low back pain. The request is for Topamax 200 Mg (2 Per Day) Unspecified Qty. There is no RFA provided and the patient's work status is not provided. The patient has been taking this medication as early as 03/05/14. Regarding topiramate (Topamax), MTUS Guidelines, page 21, states, Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy and neuropathic pain of central etiology. It is still considered for use for neuropathic pain when other anticonvulsants have failed. MTUS Guidelines, pages 16 and 17, regarding antiepileptic drugs for chronic pain, also states that, there is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy. The patient is diagnosed with lumbar degenerative disc disease, intradiscal pain, and reactive myofascitis. She has a decreased range of motion for the lumbar spine, a positive straight leg raise, an antalgic gait, and myofasciitis in the lumbosacral junction down to the sacroiliac area.

MTUS Guidelines page 60 requires documentation of medication efficacy in terms of pain reduction and functional gains when used for chronic pain. In this case, there is no documentation of pain and functional improvement with the use of Topamax. Therefore, the requested Topamax is not medically necessary.

**Lidoderm 5% patches, Qty 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain chapter - Lidoderm patches.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical lidocaine Topical analgesic Medications for chronic pain Page(s): 56-57, 111-113, 60. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, urine drug testing.

**Decision rationale:** The patient was injured on 09/16/03 and presents with severe low back pain. The request is for Methadone 10 Mg Qty 240 (30 Day Supply). There is no RFA provided and the patient's work status is not provided. The patient has been using these patches as early as 03/05/14. MTUS chronic pain medical treatment guidelines page 57 states, Topical lidocaine may be recommended for a localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI antidepressants, or an AED such as gabapentin or Lyrica). MTUS page 112 also states, Lidocaine indication: Neuropathic pain, recommended for localized peripheral pain. In reading ODG Guidelines, it specifies the Lidoderm patches are indicated as a trial if there is evidence of localized pain that is a consistent with a neuropathic etiology. ODG further requires documentation of the area for treatment, trial of a short-term use with outcome, documenting pain and function. MTUS page 60 required recording of pain and function when medications are used for chronic pain. The patient is diagnosed with lumbar degenerative disc disease, intradiscal pain, and reactive myofascitis. She has a decreased range of motion for the lumbar spine, a positive straight leg raise, an antalgic gait, and myofasciitis in the lumbosacral junction down to the sacroiliac area. There is no indication of where these patches will be applied to nor is there any documentation of localized neuropathic pain as required by MTUS Guidelines. Therefore, the requested Lidoderm patch is not medically necessary.

**Trazodone 100 mg, 2 every night, unspecified qty:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Mental Illness & Stress - Insomnia.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15. Decision based on Non-MTUS Citation Official disability guidelines Mental/stress chapter, Trazodone (Desyrel).

**Decision rationale:** The patient was injured on 09/16/03 and presents with severe low back pain. The request is for Trazodone 100 Mg, 2 Every Night, Unspecified Qty. There is no RFA provided and the patient's work status is not provided. The patient has been taking this

medication as early as 03/05/14. Regarding antidepressants, MTUS Guidelines pages 13-15, Chronic Pain Medical Treatment Guidelines: Antidepressants for chronic pain states, Recommended as a first-line option for neuropathic pain, and has a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within few days to a week, whereas antidepressant effect takes longer to occur. Trazodone is also used for insomnia, and ODG supports it if insomnia and depression are documented. The patient is diagnosed with lumbar degenerative disc disease, intradiscal pain, and reactive myofascitis. She has a decreased range of motion for the lumbar spine, a positive straight leg raise, an antalgic gait, and myofasciitis in the lumbosacral junction down to the sacroiliac area. In this case, none of the reports provided indicate that the patient has depression or insomnia. MTUS page 60 requires documentation of pain assessment, functional changes when medications are used for chronic pain. There is no discussion provided regarding medication efficacy from Trazodone. Therefore, the requested Trazodone is not medically necessary.