

Case Number:	CM15-0087844		
Date Assigned:	05/12/2015	Date of Injury:	04/07/2008
Decision Date:	06/26/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	05/07/2015

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: Connecticut, California, Virginia
 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 52 year old female who sustained an industrial injury on 4/7/08. The injured worker was diagnosed as having cervical sprain, bilateral shoulder tendonitis, lumbar sprain, bilateral wrist carpal tunnel syndrome and bilateral knee post-traumatic arthritis chondromalacia. Currently, the injured worker was with complaints of pain in the neck, shoulders, bilateral upper extremities, back and knee. Previous treatments included medication management, transcutaneous electrical nerve stimulation unit and home exercise program. Physical examination was notable for tenderness to palpation to paravertebral muscle, crepitation to bilateral knees with subjective numbness and tingling noted to bilateral wrists and forearms. The plan of care was for medication prescriptions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topamax 50 mg #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain, Topiramate (Topamax).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antiepileptics Page(s): 29.

Decision rationale: The use of topiramate is clearly addressed by the MTUS guidelines with respect to use in cases of chronic pain. 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. The provided documents do not provide clear evidence that previous attempts at treatment with first-line anticonvulsants have failed, and therefore given the provided records and the position of the MTUS, the request for treatment with topiramate, at this time, is not medically necessary.

Norco 10/325 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Utilization Review reasonably modified the request to facilitate appropriate weaning. Given the lack of lack of evidence to support functional improvement on the medication and the chronic risk of continued treatment, the request is not medically necessary.

Percocet 10 325 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate.

Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Utilization Review reasonably modified the request to facilitate appropriate weaning. Given the lack of evidence to support functional improvement on the medication and the chronic risk of continued treatment, the request is not medically necessary.

B-12/Toradol injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) [www.odgtreatment.com] www.odgtreatment.com Work loss data institute [www.worklossdata.com] www.worklossdata.com pain chronic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 72.

Decision rationale: The CA MTUS clearly states that ketorolac (Toradol) is not for use in cases of minor or chronic pain. In this case, the chronic nature of the case is a clear indication against the use of ketorolac, and without clear evidence of acute pain exacerbation requiring acute treatment in the provided documents, use of Toradol is not considered appropriate per the regulations. Therefore the request is not medically necessary based on the guidelines and provided records.