

Case Number:	CM14-0119918		
Date Assigned:	09/16/2014	Date of Injury:	07/05/2007
Decision Date:	10/29/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	07/30/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 45 year old female who sustained an injury on 07/05/07 when she tripped injuring her right knee. The injured worker is status post right knee arthroscopy as well as revision arthroscopic procedures. The injured worker did attend post-operative physical therapy. The injured worker had been followed for chronic complaints of knee and low back pain. The injured worker had previously attended acupuncture; however, the injured worker reported feeling ill from this. Prior medications included Lyrica which was discontinued. There was noted opioid tolerance to Morphine and Norco. There was a clinical report dated 07/30/14 which noted pain with activity. The injured worker was noted to be working. Medications included Naproxen, Wellbutrin, Lorazepam, Topamax, Percocet 10/325mg q6h, Fentanyl 25mcg/hr and Ambien. The physical exam noted loss of range of motion in the right knee with crepitus. There was noted muscular atrophy in the right lower extremity. The injured worker was reported to have improved with opioid rotation and discontinuation of MS Contin. The injured worker reported overall improvement in function. The requested medications were denied on 07/15/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCOCET 10/325 MG #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 88-89.

Decision rationale: The injured worker has recently undergone a rotation of medications to Fentanyl and Percocet which are providing good relief from the injured worker's ongoing chronic right lower extremity pain. The injured worker is noted to have significantly increased functions with this medication as she is now working. The injured worker has reported improved pain with the rotation to this medication. Given documented efficacy of this medication and the lack of any indications regarding non-compliance, this reviewer would recommend this request as medically necessary.

FENTANYL PATCH 25 MCG/HR #10: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 88-89.

Decision rationale: The injured worker has recently undergone a rotation of medications to Fentanyl and Percocet which are providing good relief from the injured worker's ongoing chronic right lower extremity pain. The injured worker is noted to have significantly increased functions with this medication as she is now working. The injured worker has reported improved pain with the rotation to this medication. Given documented efficacy of this medication and the lack of any indications regarding non-compliance, this reviewer would recommend this request as medically necessary.

TOPAMAX 100 MG # 60 WITH 3 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptics Page(s): 16-22.

Decision rationale: In review of the clinical documentation provided, the requested Topamax 100mg quantity 60 with three refills would not be supported as medically necessary per current evidence based guideline recommendations. Topamax is utilized for seizures and epilepsy. There is an off label indication for headaches however the efficacy of this medication for chronic migraine headaches is not well established in the literature. There is no indications that the injured worker has failed 1st line medications for the treatment of neuropathic pain as recommended by current evidence based guidelines for the use of Topamax. As such, this reviewer would not have recommended this medication as medically necessary.

BUPROPION 150 MG # 60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

Decision rationale: In review of the clinical documentation provided, the requested bupropion 150gm quantity 60 would be supported as medically necessary per current evidence based guideline recommendations. Wellbutrin is an antidepressant that has been effective in the treatment of neuropathic pain as well as chronic pain. In this case, the injured worker's chronic pain is secondary to neuropathic type symptoms in the right lower extremity. This medication would be considered appropriate for this injured worker's condition per current evidence based guidelines. As such, this reviewer would recommend this requested medication as medically necessary.