MAXIMUS Federal Services

| Case Number: | CM14-0130280 | | |
|---|---|---|---|
| Date Assigned: | 09/26/2014 | Date of Injury: | 02/16/2010 |
| Decision Date: | 10/27/2014 | UR Denial Date: | 07/15/2014 |
| Priority: | Standard | Application Received: | 08/14/2014 |

## 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 38-year-old female with a date of injury of 02/16/2010. The listed diagnoses per [redacted] are:1.Cervical myoligamentous injury with right upper extremity radiculopathy.2.Right lower extremity complex regional pain syndrome.3. Spinal cord stimulator placement, 2012.4.Status post numerous right foot and ankle surgeries and subsequent infection.5.Painful IPG, right buttock.6.Status post implantation of non-rechargeable IPG with implantation of a Medtronic IPG, 04/25/2013.7.Medication-induced gastritis.8.Left lower extremity CRPS after traumatic incident. 9. Frequent headaches.10.Pregnancies/miscarriage, May 2014.According to progress report 05/05/2014, the patient complains of pain in both lower extremities, typical of her CRPS symptoms. She rates her pain on this date, 8/10 in intensity. Patient's medication regimen includes Duragesic 50 mcg, Roxicodone 15 mg, Prozac 20 mg, Soma 350mg, Topamax 200 mg, Prilosec 20 mg, and Imitrex 100 mg. Treater is requesting a refill of medications. Utilization Review denied the request on 07/15/2014. Progress reports from 01/10/2014 through 05/09/2014 were reviewed.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**DURAGESIC 50 MCG # 15:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS , Medications for chronic pain Page(s): 60, 61 76-78.

**Decision rationale:** This patient complains of pain in both lower extremities, typical of her CRPS symptoms. The treater is requesting Duragesic 50 mcg #15. For opiate management, MTUS Guidelines pages 88 and 89 state, "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 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior).The treater documents pain level utilizing a pain scale and continually states that current medication regimen provides pain relief. Each progress report states "we routinely review and the patient must demonstrate improve function restoration, ADLs, sleep pattern, elevated mood, and ability to RTW in order to continue oriented effectives." Treater also discusses possible aberrant behaviors and patient is counseled on benefits of this medications and potential side effects. Although the treater provides pertinent information regarding analgesia and medication management, there is no specific functional improvement with taking these medications. Treater continually notes that the patient must demonstrate functional improvement for continuation, but these improvements are not noted. MTUS page 60 require recording of pain and function on each visitation when medications are used for chronic pain. Given the lack of sufficient documentation for opiate management, Duragesic 50 mcg # 15 is not medically necessary.

**TOPAMAX 200 MG # 90:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS.

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

**Decision rationale:** This patient complains of pain in both lower extremities, typical of her CRPS symptoms. The treater is requesting a refill of Topamax 200 mg #90. According to MTUS Guidelines page 21, "Topiramate (Topamax) 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 have failed." MTUS Guidelines page 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 had been directed at postherpetic neuralgia and painful polyneuropathy." In this case, progress reports note neuropathic pain in the lower extremities. MTUS Guidelines support antiepileptic medications for the use of neuropathic pain. The requested Topamax is medically necessary and recommendation is for approval.

**ROXICODONE 15 MG # 120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88, 89, 76-78.

**Decision rationale:** This patient complains of pain in both lower extremities, typical of her CRPS symptoms. The treater is requesting a refill of Roxicodone 15 mg #120. For opiate management, MTUS Guidelines pages 88 and 89 state, "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 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior).Medical records indicate the patient has been prescribed Roxicodone since at least 1/10/14. Although the treater provides a numerical scale to assess the pain, there are no outcomes measures or mention of specific functional improvement in terms of ADL's or return to work as required by MTUS. Given the lack of sufficient documentation, the patient should slowly be weaned off Roxicodone as outlined by MTUS Guidelines. Roxicodone 15 MG # 120 is not medically necessary.