

Case Number:	CM14-0140152		
Date Assigned:	09/08/2014	Date of Injury:	06/21/2005
Decision Date:	10/30/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	08/29/2014

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 Neuromusculoskeletal Medicine and is licensed to practice in Arizona. 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:

This is a 57-year-old male who sustained a work related injury on 6/21/2005 as result of tightening a tool and experienced pain in his right upper extremity. Since then, he has complained of neck, shoulder, thoracolumbar and bilateral knee discomfort. His cervical pain is reported as 8/10 in intensity. Upon examination, he has identifiable range of motion restrictions of primarily the cervical and thoraco-lumbar spine. His upper extremity examination identifies strength deficit of the entire left upper extremity (4/5 on strength testing). Upon palpation, he has paravertebral muscle spasming and spinous process tenderness of the thoraco-lumbar region. His straight leg raise and provocative orthopedic testing (Bragard's, Kemp, Lasegue, Valsalva) are positive bilaterally. Upon examination of his knees he exhibits bilateral medial joint space and inferior patellar tenderness upon palpation with positive bilateral varus and valgus stress testing. MRI of the cervical, knee and thoracolumbar regions identifies multilevel disc protrusions in the cervical region, medial / lateral and medial collateral ligamentous tearing of the bilateral knees and multi-level disc protrusions in the lower lumbar. MRI of the right shoulder identifies a supraspinatus, infraspinatus and subscapularis partial tendon tearing, a superior labrum anterior and posterior (SLAP) type tearing, an anterior glenoid labrum tear, subacromial / subdeltoid bursitis and acromioclavicular joint (AC) joint osteoarthritis. The patient successfully weaned himself off of MS Contin following a lumbar epidural steroid injection performed on October 17, 2013. Prior listed medication use, other than listed on March 5, 2014, not available. In dispute is a decision for Topamax 50mg, BID #60 and Lorazepam 0.5mg QD #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topamax 50 Bid #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16, 17 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTION AND TREATMENTS Page(s): 17, 21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Anti-epilepsy drugs (AEDs) for pain

Decision rationale: Topiramate (Topamax, no generic available) 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. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. (Eisenberg, 2007) (Jensen, 2006) After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. According to the ODG guidelines, Anti-epilepsy drugs (AED's) are recommended for neuropathic pain (pain due to nerve damage), but not for acute nociceptive pain (including somatic pain). 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 (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. Following review of the provided medical documentation, there were no found neuropathic / radicular pain warranting the use of a trial of an anti-epileptic medication. Therefore, the request is not medically necessary.

Lorazepam 0.5mg QD #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24, 66.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Benzodiazepines

Decision rationale: Benzodiazepines are Not Recommended as first-line medications by ODG. Criteria for use include: 1) Indications for use should be provided at the time of initial prescription. 2) Authorization after a one-month period should include the specific necessity for ongoing use as well as documentation of efficacy. Not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. Benzodiazepines are a major cause of

overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities). Tolerance to hypnotic effects develops rapidly (3-14 day). Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. The best prevention for substance use disorders due to benzodiazepines is careful prescribing. Adults who use hypnotics, including benzodiazepines such as temazepam, have a greater than 3-fold increased risk for early death, according to results of a large matched cohort survival analysis. Benzodiazepines (and muscle relaxants) are for use for short term treatment of muscle spasticity. Prior to the use of Lorazepam, the patient was prescribed FexMed (Cyclobenzaprine). Long term use of these medications is not medically indicated nor supported by provided CA MTUS guidelines.

