

Case Number:	CM15-0012269		
Date Assigned:	01/30/2015	Date of Injury:	11/03/2008
Decision Date:	03/30/2015	UR Denial Date:	01/21/2015
Priority:	Standard	Application Received:	01/22/2015

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, Arizona
 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 53-year-old male who reported an injury on 11/03/2008. The mechanism of injury was a fall. He is diagnosed with internal derangement of the right knee with patellofemoral chondromalacia and loose bodies. His past treatments have included physical therapy, chiropractic treatment, home exercise, work restrictions, and steroid injections to the knee. On 01/07/2015, the injured worker was seen for followup with reports of continued right knee pain despite a recent cortisone injection. Physical examination revealed tenderness, decreased range of motion, and a positive McMurray's test to the right knee. A recommendation was made for a right knee surgery with arthroscopy, decompression, and lateral meniscus repair. Other recommendations included preoperative clearance and labs, a 21 day rental of a Polar Care unit, an ELS range of motion brace, crutches, amoxicillin for postoperative infection, Zofran for postoperative nausea, and Topamax for neuropathic pain. The 01/21/2015 determination letter indicates that the requested surgery, preoperative clearance, preoperative labs, crutches, amoxicillin, and Zofran were approved and the cold therapy unit was modified to a 7 day rental. However, the ELS brace and Topamax were denied. The determination letter dated 02/09/2015 indicated that appeal requests were submitted and the cold therapy unit was modified for 7 days, the ELS brace was approved, and the request for Topamax was modified for a quantity of 60 as the 7 day use of cold therapy unit was indicated after surgery, the ELS brace was necessary to prevent falls in the postoperative period, and the Topamax was indicated for the patient's neuropathic pain related to diabetes mellitus.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topamax 50mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-17.

Decision rationale: According to the California MTUS Guidelines, Topamax has been shown to have variable efficacy with failure to demonstrate efficacy and neuropathic pain of central ideology. However, it is still considered for use for neuropathic pain when other anticonvulsants have failed. The clinical information submitted for review indicated that the injured worker had neuropathic pain related to diabetes. Therefore, a trial of use of Topamax may be appropriate. However, the submitted documentation did not clearly outline that he had tried and failed first line anticonvulsant medications prior to being prescribed Topamax, and the requested quantity exceeds an appropriate quantity for a trial prior to proceeding with therapy. For these reasons, the request is not medically necessary.

Associated surgical services: Cold therapy unit x 21 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 6th Edition (web), 2008 Knee, Hand-Continuous flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & leg, Continuous-flow cryotherapy.

Decision rationale: According to the Official Disability Guidelines, continuous flow cryotherapy is recommended for up to 7 days after surgery. The clinical information submitted for review indicated that the injured worker was approved for a right knee surgery. Therefore, the use of a cold therapy unit for 7 days would be supported. However, the request as submitted was for 21 days which exceeds the guideline recommendations. As such, the request is not medically necessary.