

<b>Case Number:</b>	CM15-0116769		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	06/16/2007
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	06/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2015

### 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

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 56 year old female with an industrial injury dated 06/16/2007. The mechanism of injury is documented as a fall. Her diagnoses included lumbosacral spondylosis, degenerative lumbar/lumbosacral disc, and pain in joint - shoulder, pain in joint - lower leg, spasm of muscle and chronic pain syndrome. Prior treatment included acupuncture, physical therapy, chiropractic treatments, epidurals in the neck and back, biofeedback, surgery and medications. She presents on 05/19/2015 with complaints of back, neck, shoulder and knee pain. She rates the pain at 5 for least pain and worst pain at 8. She describes it as throbbing, aching and pins and needles. Physical exam noted decreased range of motion of the lumbar/thoracic spine. Lumbar spine was tender to palpation with spasm. There was pain with facet loading maneuvers. Pain was present in bilateral shoulders. Bilateral fluoroscopy guided medial branch block was done at the visit. Plan of treatment included Percocet, Zanaflex and Topamax. Other treatments included were bilateral lumbar 4-5 medial branch blocks and urine drug screen. The provider documents the opioid medication was decreasing pain level and improving function. The injured worker denies any intolerable side effects. The provider documents the injured worker denies any diversion of medications or aberrant drug taking behaviors. The provider notes a review of patient activity report via the department of justice website was consistent. Urine drug screen was collected and a new pain management agreement was reviewed and signed by the injured worker. The request for Tizanidine 4 mg # 60 was authorized. The request for review is Percocet 10/325 mg # 90 and Topamax 25 mg # 90.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) 74-96.

**Decision rationale:** Pain symptoms and clinical findings remain unchanged for this chronic injury of 2007. Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or returned to work status. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury. In addition, submitted reports have not adequately demonstrated the specific indication to support for chronic opioid use without acute flare-up, new injuries, or progressive clinical deficits to support for chronic opioids outside recommendations of the guidelines. The Percocet 10/325mg #90 is not medically necessary or appropriate.

**Topamax 25mg #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), Topiramate, Page 16-22.

**Decision rationale:** Per MTUS Guidelines, Topamax is recommended for limited use in select chronic pain patients as a fourth- or fifth-line agent and indication for initiation is upon failure of multiple other modalities such as different NSAIDs, aerobic exercise, specific stretching exercise, strengthening exercise, tricyclic anti-depressants, distractants, and manipulation. This has not been documented in this case nor has continued use demonstrated any specific functional benefit on submitted reports from treatment previously rendered. There is no failed conservative first-line treatment modality, documented ADL limitations of neuropathic origin, or acute flare-up or red-flag conditions to support for its use. The Topamax 25mg #90 is not medically necessary or appropriate.