

Case Number:	CM15-0098596		
Date Assigned:	05/29/2015	Date of Injury:	03/29/2011
Decision Date:	07/07/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	05/21/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 47 year old male, who sustained an industrial injury on March 29, 2011. He reported low back pain and lower extremity pain. The injured worker was diagnosed as having sciatica, post-laminectomy syndrome of the cervical spine, disorders of the sacrum and spinal stenosis in the lumbar region. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention of the cervical spine, electrodiagnostic studies of the lower extremities with positive left lower extremity radiculitis, conservative care, medications and work restrictions. Currently, the injured worker complains of continued low back pain with lower extremity radiculitis. The injured worker reported an industrial injury in 2011, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Evaluation on March 11, 2015, revealed continued symptoms as noted. It was noted at this time the injured worker did not wish to proceed with lumbar surgery. Lifting was restricted and medications were renewed. A retrospective request was made for multiple medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request: Topiramate-Topamax 25mg #60 (DOS 1/12/15, 2/11/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Topamax <http://www.rxlist.com/topamax-drug/side-effects-interactions.htm>.

Decision rationale: TOPAMAX (topiramate) Tablets and TOPAMAX (topiramate capsules) Sprinkle Capsules are indicated as initial monotherapy in patients 2 years of age and older with partial onset or primary generalized tonic-clonic seizures. It also indicated for headache prevention. It could be used in neuropathic pain. Although the patient has a history of ongoing chronic neuropathic pain, there is no documentation of ongoing efficacy and functional improvement with the previous use of the medication. Therefore the retrospective prescription of Topamax 25mg #60 is not medically necessary.

Retrospective request: Orphenadrine-Norflex 100mg #90 (DOS 1/12/15, 2/11/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY DRUGS Page(s): 66.

Decision rationale: According to MTUS guideline, Orphenadrine (Norflex, Banflex, Antiflex, Mio-Rel, Orphenate, generic) is a muscle relaxant with anticholinergic effects. MUTUS guidelines stated that a non-sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case does not have clear and recent evidence of acute exacerbation of spasm. Therefore, the retrospective request of Norflex 100mg #90 is not medically necessary.

Retrospective request: Tramadol ER 150mg #30 (DOS 1/12/15, 2/11/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic trial of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113.

Decision rationale: According to MTUS guidelines, Ultram (Tramadol) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing

monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug- related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. In this case, there is no clear evidence of objective and recent functional and pain improvement from the previous use of Tramadol. There is no clear documentation of the efficacy/safety of previous use of tramadol. There is no recent evidence of objective monitoring of compliance of the patient with his medications. Therefore, the retrospective prescription of Tramadol ER 150mg #30 is not medically necessary.

Retrospective request: Diclofenac 1.5% 60gms (DOS 1/12/15, 2/11/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NONSELECTIVE NSAIDS, Topical Analgesics Page(s): 107, 111.

Decision rationale: Diclofenac is a non-steroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis pain of wrist, ankle and elbow and there is no strong evidence for its use for spine pain such as cervical spine pain and shoulder pain. There is no evidence of failure of neuropathic pain agents. Therefore, the retrospective request for Diclofenac Sodium 1.5% cream, 60gr is not medically necessary.

Retrospective request: Trazodone 50mg #90 (DOS 1/12/15, 2/11/15): 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), insomnia treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Schwartz, T., et al. (2004). "A comparison of the effectiveness of two hypnotic agents for the treatment of insomnia". Int J Psychiatr Nurs Res 10(1): 1146-1150.

Decision rationale: There is no clear evidence that the patient was diagnosed with major depression requiring Trazodone. There is no formal psychiatric evaluation documenting the diagnosis of depression requiring treatment with Trazodone. In addition, there is no documentation of failure of first line treatments for insomnia and depression. Therefore, the retrospective request for Trazodone 50 MG #90 is not medically necessary.