

Case Number:	CM14-0104916		
Date Assigned:	07/30/2014	Date of Injury:	09/16/1996
Decision Date:	08/29/2014	UR Denial Date:	06/18/2014
Priority:	Standard	Application Received:	07/07/2014

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, and is licensed to practice in Nevada. 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 records presented for review indicate that this 58 year-old female was reportedly injured on 9/16/1996. The mechanism of injury is not listed in the records reviewed. The most recent progress notes dated 4/3/2014 and 5/29/2014, indicates that there are ongoing complaints of low back and neck pain. Physical examination demonstrated difficulty on the heels; decreased right Patella reflex and bilateral Achilles reflexes; positive right straight leg raise with pain into the groin and lateral leg. MRI of the lumbar spine dated 6/24/2010 showed spinal stenosis at L2-L4, postsurgical changes at L5-S1, right-sided disk protrusion at L1-L2 and L4-L5. Previous treatment includes chiropractic treatment, lumbar epidural steroid injections and medications to include Norco, Relafen, Lodine, Neurontin, Tramadol ER, Amitriptyline, and Lidoderm Patches. A request had been made for Amitriptyline 10 mg #240; Tramadol ER #120; and Neurontin 300 mg #180 in utilization review on 6/18/2014. A partial certification was granted for Amitriptyline #60 and Neurontin #60; and Tramadol ER was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline 10 mg tabs (# 60 with 3 refills QTY 240.00): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16, 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page 13, 15 of 127 Page(s): 13, 15 OF 127.

Decision rationale: MTUS guidelines support the use of tricyclic antidepressants in chronic pain management and consider tricyclics a first-line option in the treatment of neuropathic pain. Elavil (Amitriptyline) is a tricyclic antidepressant medication and is considered medically necessary.

Tramadol ER (150mg) QTY 120.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-83.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page 82, 113 of 127 Page(s): 82, 113 OF 127.

Decision rationale: MTUS guidelines support the use of Tramadol (Ultram) for short-term use after there is been evidence of failure of a first-line option, evidence of moderate to severe pain and documentation of improvement in function with the medication. Review of the available medical records, fails to document long-term functional improvement with this medication and/or failure of a first-line option. Furthermore, the claimant has been prescribed hydrocodone which is a short acting opiate. Given the date of injury and clinical presentation, this request is not considered medically necessary.

Neurontin 300mg QTY 180.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19, 49, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 16-20, 49 of 127 Page(s): 16-20, 49 OF 127.

Decision rationale: MTUS guidelines support Gabapentin (Neurontin) as a first-line treatment for neuropathic pain. Based on the clinical documentation provided, there is evidence of lumbar radicular/neuropathic pain. As such, the requested medication is medically necessary.