

<b>Case Number:</b>	CM14-0025968		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	06/13/2000
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	02/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 injured worker is a 42 year old female who reported an injury on 06/13/2000 due to an unknown mechanism of injury. The injured worker complained of chronic back pain. On 04/02/2014 the physical examination revealed decreased range of motion, positive straight leg raise on left with radiation to left foot at 40 degrees. She rated her pain at a 7/10. There was no documentation of any diagnostic studies provided. The injured worker has diagnoses of chronic back pain, left leg radiculopathy, and a herniated disc. The past treatment for the injured worker has been medication therapy. There was no documentation provided regarding additional conservative care. The injured worker is on the following medications Motrin 600mg, Baclofen 10mg, Percocet 10mg, Amitriptyline 150mg, Imitrex 100mg, and Zoloft 100mg. The current treatment plan is for Amitriptyline 150mg. The rationale and request for authorization was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AMITRIPTYLINE 150MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain, page Page(s): 13.

**Decision rationale:** The injured worker has a history of chronic back pain. The California MTUS guidelines state that antidepressants for chronic pain are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. The guidelines also state that the assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. The documentation submitted for review indicated subjective complaints, and limited objective findings. There was lack of documentation in regards to pain outcomes, evaluation of function, sleep quality and duration, and psychological assessment. The level of treatment efficacy was not provided thus, making the request for Amitriptyline not supported. In addition, there was no mention of a lack of side effects and the request does not include the frequency or quantity of the medication. Therefore, the request for Amitriptyline 150mg is not medically necessary.