

<b>Case Number:</b>	CM15-0009437		
<b>Date Assigned:</b>	01/27/2015	<b>Date of Injury:</b>	08/28/2004
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	12/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2015

### 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 49-year-old male who reported an injury on 08/28/2004. The mechanism of injury was not provided. The surgical history included a lumbar spine surgery, however, the specific procedure and date were not provided. The injured worker underwent a CT scan. The injured worker underwent lumbar epidural steroid injection. The injured worker was undergoing urine drug screens. The injured worker underwent an MRI of the lumbar spine without contrast. The documentation of 11/25/2014 revealed the injured worker had complaints of low back pain and right greater than left radicular pain. The injured worker indicated the pain was in the low back and the anterior side to the knee. The pain was worse with walking. The injured worker had a spinal cord stimulator that was helping to reduce the pain. The surgical history included a gunshot wound on 07/31/1994. The injured worker had a spinal cord stimulator implantation on 05/10/2013. The injured worker indicated that the interval pain over the prior week was 7/10 to 9/10 and with the medication the relief was 30% to 40%. The injured worker was administered the PHQ 9 Depression Index and was noted to have moderately severe depression symptoms. The physical examination revealed the injured worker had decreased range of motion in flexion, extension and rotation with increased pain. The straight leg raise was positive on the right. The injured worker had tenderness to palpation over the lumbar spine. Sensation to light touch was decreased in the L3 distribution. The strength of the right lower extremity was 4/5. The injured worker had an antalgic gait. The request was made for an increase of the Norco and a continuation of the Nortriptyline. The injured worker was noted to be previously treated with physical therapy. The diagnoses included lumbago and degeneration of lumbar or lumbosacral

intervertebral disc, sciatica, and postlaminectomy syndrome of the lumbar region. There was no request for authorization submitted for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325 MG #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Ongoing Management Page(s): 60; 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker's is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had an objective decrease in pain and was being monitored for aberrant drug behavior. There was a lack of documentation indicating the injured worker was being monitored for side effects and that the injured worker had an objective increase in function with the use of the medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 10/325 MG #90 is not medically necessary.

**Nortriptyline Hydrochloride 10 MG #60 with 2 Refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend antidepressants as a first line medication for the treatment of neuropathic pain and they are recommended especially if the pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement. The clinical documentation submitted for review indicated the injured worker had an objective decrease in pain. However there was a lack of documentation of objective functional improvement. The injured worker was administered the PHQ 9 Depression Index and was noted to have moderately severe depression symptoms. The request as submitted failed to indicate the frequency for the requested medication. There is a lack of documentation indicating the necessity for 2 refills without re-evaluation. Given the above, the request for Nortriptyline Hydrochloride 10 MG #60 with 2 refills is not medically necessary.

