

Case Number:	CM15-0100913		
Date Assigned:	06/03/2015	Date of Injury:	04/01/2013
Decision Date:	07/01/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/26/2015

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: Emergency 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:

This is a 46 year old female with an April 1, 2013 date of injury. A progress note dated April 14, 2015 documents subjective findings (left shoulder pain rated at a level of 2/10 and goes up to 8/10 intermittently; issues with sleep), objective findings (left shoulder abduction almost full range of motion in all planes with mild pain; tender left acromioclavicular joint area; right medial epicondyle moderate tenderness), and current diagnoses (bilateral carpal tunnel syndrome; left shoulder superior labrum anterior to posterior lesion tear and rotator cuff tendinosis; left elbow tendinosis and right biceps tendon tear). Treatments to date have included physical therapy (helping with strength and range of motion), medications (complaints of gastrointestinal irritation), and left shoulder arthroscopy. The treating physician documented a plan of care that included Amitriptyline.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline 25mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-15.

Decision rationale: The requested Amitriptyline 25mg #30, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Antidepressants for Chronic Pain, Pages 13-15, recommend tricyclic antidepressants as a first-line agent for the treatment of chronic pain, neuropathic pain and depression, "unless they are ineffective, poorly tolerated, or contraindicated." The injured worker has low back pain with radiation to the left lower extremity. The injured worker has subjective findings (left shoulder pain rated at a level of 2/10 and goes up to 8/10 intermittently; issues with sleep), objective findings (left shoulder abduction almost full range of motion in all planes with mild pain; tender left acromioclavicular joint area; right medial epicondyle moderate tenderness). The treating physician has not documented duration of treatment, or objective evidence of derived functional improvement from its use. The criteria noted above not having been met, Amitriptyline 25mg #30 is not medically necessary.