

Case Number:	CM15-0144005		
Date Assigned:	08/04/2015	Date of Injury:	08/20/2011
Decision Date:	09/22/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	07/24/2015

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: Pennsylvania, Ohio, California
 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 a 56 year old female, who sustained an industrial injury on August 20, 2011. Treatment to date has included psychiatric and psychological care, anti-depressants and other medications. Currently, the injured worker complains of waking daily with pain. She reports that she does not sleep and feels radiculopathy at night. She reports that she wants to get out of the system and she has been sober for six months as of May 26, 2015. On physical examination the injured worker had a depressed mood and was anxious. Her motor activity was calm, her speech was normal and she was coherent. Her thought pattern, language and knowledge were within normal limits and her judgment and attention were intact. Her mental status was intact and she was cooperative. She was cooperative and her memory was intact. Her gait was non-antalgic and she did not use assistive devices. The diagnoses associated with the request include recurring major depression. The treatment plan includes amitriptyline, gabapentin, Ritalin and trazodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline 50mg #120 with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tricyclic Antidepressants Page(s): 122.

Decision rationale: MTUS recommends tricyclic antidepressants as a first-line treatment in chronic pain. A prior physician review recommended non-certification of this medication due to lack of objective functional benefit. However MTUS supports the use of this medication based on subjective improvement rather than structure functional improvement. Treatment guidelines have been met. This request is medically necessary.

Gabapentin 800mg #120 with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs /Gabapentin Page(s): 18.

Decision rationale: MTUS recommends Gabapentin as a first-line treatment in chronic pain. A prior physician review recommended non-certification of this medication due to lack of objective functional benefit. However MTUS supports the use of this medication based on subjective improvement rather than structure functional improvement. Treatment guidelines have been met. This request is medically necessary.

Ritalin 20mg #90 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation JAMA 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA Approved Labeling Information for Ritalin.

Decision rationale: FDA Approved Labeling Information for Ritalin supports this medication as indicated for attention deficit disorder or narcolepsy. The records do not clearly document clinical reasoning to support either of these diagnoses, nor do the records clearly provide an alternative basis for this treatment to be considered medically necessary. Therefore this request overall is not medically necessary.

Trazodone 100mg #30 with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental / Trazodone.

Decision rationale: MTUS does not discuss indications for Trazodone. ACOEM Chapter 6 Chronic Pain Revised 99 does discuss Trazodone and states that this anti-depressant is strongly not recommended for treatment of chronic pain without depression. ODG states that trazodone is recommended as an option for insomnia for patients with co-existing depression or anxiety. The records do meet these criteria to document a rationale and indication for Trazodone, thus the records do provide clinical reasoning to support this request. The request is medically necessary.