

<b>Case Number:</b>	CM15-0168593		
<b>Date Assigned:</b>	09/09/2015	<b>Date of Injury:</b>	07/20/2003
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 65 year old female who sustained an industrial injury on 07-20-1003. Mechanism of injury occurred after lifting a box of frozen fish from a conveyor. Diagnoses include backache and post laminectomy syndrome. The most recent and only physician progress note dated 06-08-2014 documents the injured worker states her pain is unchanged since her last visit and rates her pain with medications as a 3 out of 10 and without medications as 6 out of 10 on a scale of 1 to 10. Her quality of sleep is fair. She currently has full range of motion of both her knees but with some stiffness and she ambulates with a cane. Her back pain has increased since her last visit but is stable on her current medications. She continues to experience functional benefit from her medications with improved capability for daily household tasks. She is compliant with the pain contract and submits random urine drug screening. With her medications she is able to walk for 30-45 minutes and care for herself and her household with less pain. Her pain decreased from 8 out of 10 to 4 out of 10 with medications. She has been on the Amitriptyline since at least from 04-13-2015. Treatment to date has included diagnostic studies, status post L5-6 transforaminal interbody fusion on 03-15-2011, spinal cord stimulator trial, and bilateral total knee arthroplasties, acupuncture, physical therapy, use of a Transcutaneous Electrical Nerve Stimulation unit, facet joint injections, epidural steroid injections, HELP program, and use of a cane. Current medications include Colace, Senokot, Amitriptyline, Ambien, Wellbutrin XL, Nucynta, Neurontin, Omeprazole, Amitiza and Levothyroxine. The original utilization review dated 08-10-2015 non-certified the request for

Amitriptyline HCL 25mg #30 with 1 refill due to clinical response to previous intake has not been documented to justify continued treatment.

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

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

**Amitriptyline HCL 25mg #30 with 1 refill:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Amitriptyline.

**Decision rationale:** The California MTUS section on antidepressants and chronic pain states: Tricyclic antidepressants are recommended over selective serotonin reuptake inhibitors (SSRIs), unless adverse reactions are a problem. Caution is required because tricyclics have a low threshold for toxicity, and tricyclic antidepressant overdose is a significant cause of fatal drug poisoning due to their cardiovascular and neurological effects. Tricyclic antidepressants have been shown in both a meta-analysis (McQuay, 1996) and a systematic review (Collins, 2000) to be effective, and are considered a first-line treatment for neuropathic pain. (Namaka, 2004) (Dworkin, 2003) (Gilon, 2006) (Wolfe, 2004) (Dworkin, 2007) (Saarto-Cochrane, 2007) This class of medications works in both patients with normal mood and patients with depressed mood when used in treatment for neuropathic pain. (Sindrup, 2005) Indications in controlled trials have shown effectiveness in treating central post-stroke pain, post-herpetic neuralgia (Argoff, 2004), painful diabetic and non-diabetic polyneuropathy, and post-mastectomy pain. Negative results were found for spinal cord pain and phantom-limb pain, but this may have been due to study design. (Finnerup, 2005) Tricyclics have not demonstrated significance in randomized-control trials in treating HIV neuropathy, spinal cord injury, cisplatin neuropathy, neuropathic cancer pain, phantom limb pain or chronic lumbar root pain. (Dworkin, 2007) One review reported the NNT for at least moderate neuropathic pain relief with tricyclics is 3.6 (3-4.5), with the NNT for amitriptyline being 3.1 (2.5-4.2). The NNT for venlafaxine, calculated using 3 studies, was reported to be 3.1 (2.2-5.1). (Saarto-Cochrane, 2007) Another review reported that the NNT for 50% improvement in neuropathic pain was 2 to 3 for tricyclic antidepressants, 4 for venlafaxine, and 7 for SSRIs (Perrot, 2008). The patient has documented neuropathic pain and therefore the request is medically necessary.