

Case Number:	CM15-0182069		
Date Assigned:	09/23/2015	Date of Injury:	05/08/2006
Decision Date:	10/27/2015	UR Denial Date:	09/05/2015
Priority:	Standard	Application Received:	09/16/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 60 year old male with a date of injury of May 8, 2006. A review of the medical records indicates that the injured worker is undergoing treatment for lumbago, lumbar degenerative disc disease, lumbar facet arthropathy, post laminectomy syndrome, and lumbar spine stenosis. Medical records dated June 16, 2015 indicate that the injured worker complains of pain rated at a level of 6 to 7 out of 10 with medications. Records also indicate that the injured worker is able to perform light household chores with the use of medications. A progress note dated August 25, 2015 notes subjective complaints of pain rated at a level of 6 out of 10, intermittent periods of flare-up of neuropathic pain that radiates to the left hip and bilateral lower extremities with pressure sensation in the feet. The physical exam dated June 16, 2015 reveals gait is slow and antalgic to the right, use of a back brace, unobtainable patellar deep tendon reflexes on the right, positive straight leg raise on the right, decreased range of motion of the back, left flank tenderness to palpation, sacroiliac joint tenderness on the right, and sensory deficits in the right anterior L2-3 and right posterior L5-S1 dermatomes. The progress note dated August 25, 2015 documented a physical examination that showed no changes since the examination conducted on June 16, 2015. Treatment has included lumbar epidural steroid injection, with relief for two to four days, and medications (OxyContin 20mg twice a day, Valium 10mg one-half tablet twice a day as needed, Gabapentin 600mg three times a day since at least April of 2015; Amitriptyline HCL 50mg since at least June of 2015). The original utilization review (September 5, 2015) non-certified a request for OxyContin 20mg #90 and partially certified a request for

Amitriptyline HCL 50mg #30 (original request for Amitriptyline HCL 50mg #30 with two refills).

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Amitriptyline HCL 50mg #30 with 2 refills: Upheld

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): Antidepressants for chronic pain.

Decision rationale: 1 Prescription of Amitriptyline HCL 50mg #30 with 2 refills is not medically necessary per the MTUS Guidelines. The MTUS supports tricyclic antidepressants for chronic pain but states that an 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 patient has neuropathic pain per documentation, however a request for 2 refills of this medication is not appropriate as the MTUS requires ongoing evidence of and documentation of efficacy. This request for Amitriptyline is not medically necessary.

1 Prescription of Oxycontin 20mg #90: Upheld

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): Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids, long-term assessment.

Decision rationale: 1 Prescription of Oxycontin 20mg #90 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The MTUS states that opioids for chronic low back pain appear to be efficacious but limited for short-term pain relief, and long term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. The MTUS states that opioids are minimally indicated for neuropathic pain. There is no evidence to recommend one opioid over another. The documentation reveals that the patient has been on long-term opioids without significant evidence of an increase in function therefore the request for continued Oxycontin is not medically necessary.

