

<b>Case Number:</b>	CM15-0209964		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	08/19/1996
<b>Decision Date:</b>	12/15/2015	<b>UR Denial Date:</b>	10/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/26/2015

### 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: 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:

This 88 year old male sustained an industrial injury on 8-19-96. Documentation indicated that the injured worker was receiving treatment for spondylolisthesis, sciatica, degeneration of intervertebral disc adjustment disorder, depression and insomnia. Previous treatment included lumbar fusion (2011). Recent treatment consisted of h-wave and medication management. In a visit note dated 2-11-15, the injured worker stated that his symptoms were unchanged from previous visits with good and bad days. Physical exam was remarkable for tenderness to palpation to the lumbar spinous process and paraspinal musculature with tight muscle band, range of motion: flexion 40 degrees, extension 10 degrees and bilateral lateral bend 10 degrees and negative straight leg raise. The injured worker walked with a normal gait. Current medications included Amitriptyline, Norco, Ketorolac, Celebrex, Lexapro, Flexeril, Soma and Ambien. In a visit note dated 6-10-15, the injured worker continued to have good and bad days. The injured worker stated that Norco dropped his pain level after two hours from 8 out 10 on the visual analog scale to 4 out of 10 and enabled him to perform activities of daily living except for heavy lifting. In a visit note dated 10-6-15, the injured worker reported that his pain had remained the same since last visit, rated 5 out 10. The injured worker was trying to stay active and doing a lot of fly fishing. Physical exam and current medications were unchanged. The treatment plan included prescriptions for Norco and Amitriptyline. On 10-20-15, Utilization Review modified a request for Amitriptyline 50mg #30 with 3 refills to Amitriptyline 50mg #30 with no refills and noncertified a request for Norco 10-325mg with three refills.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Amitriptyline 50mg 3 refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain. Decision based on Non-MTUS Citation ODG.

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

**Decision rationale:** MTUS recommends Tricyclic antidepressants as a first-line agent unless ineffective or poorly tolerated or contraindicated. A prior physician review recommended non-certification due to lack of documented objective functional improvement and/or mood improvement. However, subjective reports of reduced pain or improved sleep as in this case are sufficient to support continuation of this drug class; continuation of tricyclic antidepressant treatment is particularly indicated in a case such as this where opioids have been recommended for taper or discontinuation. Therefore this request is supported by the treatment guidelines and is medically necessary.

### **Norco 10/325 with 3 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): Opioids, criteria for use, Opioids for chronic pain.

**Decision rationale:** MTUS discusses in detail the 4 As of opioid management, emphasizing the importance of dose titration vs. functional improvement and documentation of objective, verifiable functional benefit to support an indication for ongoing opioid use. The records in this case do not meet these 4As of opioid management and do not provide a rationale or diagnosis overall for which ongoing opioid use is supported. Therefore this request is not medically necessary.