

Case Number:	CM15-0213127		
Date Assigned:	11/02/2015	Date of Injury:	01/17/2008
Decision Date:	12/14/2015	UR Denial Date:	10/28/2015
Priority:	Standard	Application Received:	10/29/2015

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 44 year old male, who sustained an industrial-work injury on 1-17-08. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar strain with new onset of left adductor strain. Treatment to date has included pain medication Tramadol (gave him a queasy stomach), Motrin, Nortriptyline since at least 10-14-15, physical therapy at least 8 sessions, home exercise program (HEP), and other modalities. Medical records dated 10-14-15 indicate that the injured worker complains of a problem that began about 3 weeks ago when he was kneeling down and working on equipment. He arose and had sudden onset of sharp medial thigh and leg pain, which has not totally gone away. He also developed left heel pain at the same time. He also indicates that with this pain, his low back pain has also flared up. He reports that he has reduced the Motrin to twice weekly. He reports that he gets the low back pain when he lies down at night, the low back feels tight and he is sleeping very poorly. The work status is not noted. The physical exam reveals that he walks with a left sided limp; the left proximal adductor muscles are quite tender. The physician indicates that the injured worker has a new onset of a left adductor strain in addition to the low back pain. He was given a prescription for Nortriptyline nightly as the symptomology has worsened referable to the low back and requested Magnetic Resonance Imaging (MRI) of the lumbar spine. There are no previous diagnostics noted. The request for authorization date was 10-21-15 and requested services included Magnetic Resonance Imaging (MRI) lumbar spine and Nortriptyline 25mg (x1 refill). The original Utilization review dated 10-28-15 non-certified the request for Magnetic Resonance Imaging (MRI) lumbar spine and Nortriptyline 25mg (x1 refill).

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.

Nortriptyline 25mg (x1 refill): Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

Decision rationale: The California MTUS section on the requested medication states: Specific antidepressants: 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) (Gilron, 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 the diagnosis of lumbar strain with radicular symptoms. The requested medication is indicated as first line treatment for neuropathic pain. Therefore, the request is medically necessary.