

Case Number:	CM15-0216333		
Date Assigned:	11/05/2015	Date of Injury:	03/30/2015
Decision Date:	12/21/2015	UR Denial Date:	10/08/2015
Priority:	Standard	Application Received:	11/03/2015

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: California, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 59 year old male with a date of injury on 03-30-2015. The injured worker is undergoing treatment for cervical strain-bulge at C5-7, thoracic strain and lumbosacral strain-bulge at L4-S1. Comorbid diagnosis is Insulin dependent diabetes mellitus. A physician note dated 08-10-2015 documents the injured worker states therapy is helpful. He has pain in his neck, mid back and low back. His mid back pain is the worst. A muscle stim used in therapy helps with his spasms and he is requesting one for home use. He has a normal gait. There is positive cervical and lumbar tenderness and muscle spasms are noted in the paraspinal musculature. Cervical and lumbar spine range of motion is restricted. His medications decrease his pain by approximately 2-3 points on the pain scale. They allow improved ADL's including ability to ambulate, use the bathroom, provide self-care, cook and clean. A physician note dated 09-28-2015 documents the injured worker has complaints of lower back pain rated 8 out of 10, left leg pain rated 7 out of 10 and neck and upper and mid back pain rated 8 out of 10. There is decreased cervical range of motion. There is tenderness on the bilateral trapezius. There is tenderness to the lumbopelvic region and decreased range of motion by 50%. He is not working at this time but is looking for a job. A physician progress note dated 09-28-2015 documents the injured worker has complaints of pain in the neck, back, left leg and right knee. He rates his low back pain as 8 out of 10. He has left leg pain that is shooting burning and achy. He rates this pain as 7 out of 10. His neck upper and mid back and right knee pain is rated 8 out of 10. His pain is better with medications. There is restricted cervical range of motion. Neer impingement sign is positive bilaterally. The lumbar spine has minimal tenderness and there is decreased

range of motion. His right knee has tenderness in the medial bursa with mild tenderness in the lateral joint line and peripatellar region. There will be a trial of Pamelor and he will decrease the Norco and a trial of stopping the Ultram. Treatment to date has included diagnostic studies, medications, physical therapy, and use of an electric stimulation. Current medications include Norco, Tramadol, Cyclobenzaprine, Naproxen and Ibuprofen. In addition he takes Novolog and Lantus insulin, Metformin Hcl, Lipitor, Losartan and Advair. A urine drug screen was done on 06-10-2015. The Request for Authorization dated 10-02-2015 includes Cognitive Behavioral evaluation and 4 visits, low back and right knee chiropractic sessions, Pamelor is requested to help with the chronic pain and insomnia, and Norco is requested for severe pain as needed. On 10-08-2015 Utilization Review non-certified the request for Norco 5mg #30, Q 8hrs prn severe pain and Pamelor 10mg #60, 1-2 at night.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5mg #30, Q 8hrs prn severe pain: 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, specific drug list, Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain / Opioids for chronic pain.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, opioids (criteria for use & specific drug list): A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The 4 A's for Ongoing Monitoring include analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. Opioids may be continued if the patient has returned to work and the patient has improved function/pain. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. The ODG Pain / Opioids for chronic pain states "According to a major NIH systematic review, there is insufficient evidence to support the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms." Based upon the records reviewed there is insufficient evidence to support the medical necessity of chronic narcotic use. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance,

return to work, or increase in activity from the exam note of 9/28/15. Therefore the prescription is not medically necessary and the determination is for non-certification.

Pamelor 10mg #60, 1-2 at night: 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: Per CA MTUS Chronic Pain Medical Treatment Guidelines, Part 2 Pain Interventions and Treatments, Amitriptyline is recommended. Amitriptyline is a tricyclic antidepressant. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. See Antidepressants for chronic pain for general guidelines, as well as specific Tricyclics listing for more information and references. Under the CA MTUS section Antidepressants for chronic pain, it states that: Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Per CA MTUS guidelines antidepressants are recommended as a first-line option for neuropathic pain, especially if accompanied by insomnia, anxiety or depression. It can be used for non-neuropathic pain and has been shown to be efficacious in the following diagnoses: fibromyalgia, or chronic lower back pain. In this case the medical notes from 8/10/15 do not show that this patient has a diagnosis of neuropathic pain, fibromyalgia or chronic lower back pain. As this patient does not meet CA MTUS guidelines for the use of a tricyclic antidepressant, the request is not medically necessary.