

Case Number:	CM15-0082674		
Date Assigned:	05/05/2015	Date of Injury:	06/20/2012
Decision Date:	06/16/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	04/30/2015

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: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports 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:

The injured worker is a 54 year old male, who sustained an industrial/work injury on 6/20/12. He reported initial complaints of pain in the lower back and waist. The injured worker was diagnosed as having chronic low back pain, post laminectomy syndrome, myofascial pain. Treatment to date has included medication, home exercise program, pain management HELP functional restoration program, physical therapy, aquatic therapy, and surgery (laminectomy). X-Rays results were reported on 6/14/13 and noted no evidence of hardware failure or loosening. Currently, the injured worker complains of ongoing back pain. Per the office visit on 4/6/15 for follow up pain management, home exercises were continued with utilization of medication prescribed. Pain index was 8/10. Counseling was done regarding compliance with the treatment regimen. Vital signs demonstrated hypertension 141/91 and tachycardia at 104. Current plan of care included refill of current medication. The requested treatments include Amitriptyline HCL (Hydrochloride) and Tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline HCL (Hydrochloride) 50mg, #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline, and Antidepressants for chronic Pain. page(s) 13-14.

Decision rationale: MTUS guidelines state the following: Amitriptyline, 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. 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. (Saarto-Cochrane, 2005) 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. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken. Long-term effectiveness of anti-depressants has not been established. According to the clinical documentation provided and current MTUS guidelines, Amitriptyline is medically necessary to the patient at this time.

Tramadol 50mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, page(s) 75-79.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS indicates that ongoing management of opioids includes documentation of prescriptions given from a single practitioner, prescriptions from a single pharmacy and the lowest dose should be used to improve function. There should also be an ongoing review of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug behaviors. There is no clear functional gain that has been documented with this medication. Guidelines state that the discontinuation of opioid medication is recommended if there is no overall improvement in function. According to the clinical documentation provided and current MTUS guidelines; Tramadol is not medically necessary to the patient at this time.