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| Case Number: | CM15-0084177 | | |
| Date Assigned: | 05/06/2015 | Date of Injury: | 01/08/2002 |
| Decision Date: | 06/09/2015 | UR Denial Date: | 04/03/2015 |
| Priority: | Standard | Application Received: | 05/01/2015 |

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: New York, West Virginia, Pennsylvania
 Certification(s)/Specialty: Emergency 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 49 year old male who sustained an industrial injury on 1/8/02. The injured worker was diagnosed as having lumbosacral spondylosis without myelopathy, degeneration of lumbosacral intervertebral disc, low back pain, depressive disorder and lumbosacral neuritis. Currently, the injured worker was with complaints of back pain, left leg muscle weakness and joint pain. Previous treatments included oral pain medication and home exercise program. Previous diagnostic studies were not noted in the documentation. Previous surgical interventions include right knee surgery and right shoulder surgery. The plan of care was for medication prescriptions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nortriptyline 10mg #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Anti-depressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines Mental Illness and Stress; Anti-depressants for treatment of MDD (Major Depressive Disorder).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

Decision rationale: Guidelines do not specify insomnia as an indication for tricyclic antidepressants such as nortriptyline and insomnia is listed as a side effect of nortriptyline. In this case, the patient has sleep disturbances. The request for nortriptyline is not medically appropriate and necessary.